Peter W Dolan

		For State Unpend Item #2 Registrar Decedent's Name (First, Middle, L	ast)					2. Date of Deat Month	h	3. Time of Death
Physicia /Medica		Peter W. I	Dolan					January	8, 2004	0513 P. M
Examine		la. Facility Name (If not institution, g	ive street and number,)			Location of Death		4c. County of I	
		621 Edgewood Roa 5. Social Security Number 6.	d. Apartme	ent 127 ge (In yrs. last i	birthday)	Edgewood	If Under 24 Hrs.	8. Date of Birth (Month, Day,	Harfor	Cd. Birthplace (State or Foreign Country)
uneral rector	,	394-36-0299	10XM 2□F	64	Yrs.	Months Days	Hours Min.	NOV 19,	1939	Visconsin
	1-	Usual Residence of Decedent		10c. City, To	own or Loc	ation				10d. Inside City Limits
any injury or other traumatic event, it a Mucical Examiner must be neitified at once.		Maryland Harford	1	Edgewo		ation				1 ☐ Yes 2√ No
	Q L	10e. Street and Number		2080		10f. Zip Code		1	0g. Citizen of Wha	at Country?
		621 Edgewood Roa	ad #127			21040			USA	
	Funeral	11. Marital Status	12. Was Decedent Armed Forces	t Ever in U.S.	13. W	as Decedent of H Yes, specify Cubi	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc.
	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🂢 Divorced	1 XYes 2 If Yes, Give Year or Dates:		1	□Yes 21XNo	Specify:		Specify:	White
	ed b	15. Decedent's	Education	-	6a. Decede	ent's Usual Occup	ation		16b. Kind of Busin	ness/Industry
	piet	(Specify only highest of Elementary/Secondary (0-12)	grade completed) College (1-4or	5+)			during most of work	ng	TT C A	
	Completed	12			Maste	r Sargea		(Cina Middle I	U.S. Art	ny
	Be	17. Father's Name (First, Middle, La					18. Mother's Name		Maiden Sumame)	
	၉	Harold J. Dolan		1	9b. Mailing	Address (Street	and Number or Rura		, City or Town, Sta	ate, Zip Code)
		Judie L. Arnol					ord Circle		sta, GA	30907
1		20a. Method of Disposition		20b. Place	e of Dispos etery, crem	sition (Name of atory or other pla	(ec	Date	20c. Location - Ci	ty or Town, State
		1 ☐ Burial 2 【XCremation 3 1 ☐ Donation 5 ☐ Other (Spe		e	o Cre	ematory 1	nc. 1-1	3-04	Baltimo	re, MD
Duce.		21. Signature Quneral Service Lie	ensa		22.	Name and Addre	ss of Facility Society	of MD.	Inc.	
a	4	Edward A. 23a. Part1. Enter the disease, or co	Zregorchik	- d sb - d - sb - F	1	199 Frede	erick Road	Balt	ımore, M	D 21228 Approximate
ician		shock, or heart failure. List or Immediate Cause (Final	ity one cause on each	"Obstruct	ive Pu	ılmonary D	isease	or respiratory arr	G31,	Interval Between Onset and Death
an :al		disease or condition resulting in death)	_a complic	ated by S	Sleep A	pnea				
er	1		b.	,	,					
-	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		is a consequen	ce of):					
	Examiner	that initiated events resulting in death) Last	c	is a consequen	ice of):					
		1	d							
	edic									
	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal de	ath 3 🗌	Ectopic pregnanc	y		23d. Date of	
	sici	1 Pes 2 No	4□Pregnant 9□Unknown	at time of death	h 5□	Other (specify) _				
	Ph	Part II. Other significant condition	s contributing to death	but not resultin	ng in the un	nderlying cause gr	ven in Part I.	23e. Did to	bacco use contrib	ute to the cause of death?
	d b	Hypertension						1 🗆 Y	es 2□No 3	Probably 4 Unknown
	piete							24a. Was a	an 24b. We	ere autopsy findings available or to completion of cause of
page 2	mo							, perfor	med? dei 2□No 1↓	utb?
	BeC	25. Was case referred to medical examiner?	177-9-1				26. Place of Deat	h (Check only o	ne)	
	မ	1 X es 2□ No	Hospital:		VOutpatien	t 3 DOA			ence 6 X ther	
	tion:	27. Manner of Death 1 XNatural 5 Pending investigation	28a. Date of Ir (Month, L	Day Year)	Injury	Wo	rk?]Yes 2∐No	Lou. Boombo II	on many coomer	
	ertification;	3 Suicide 6 Could no	ot be 28e. Place of	Injury - At home	e, farm, stre	eet, factory, office		28f. Location (S City or Tow	Street and Number	or Rural Route Number,
	Cert	4 Homicide	building,	etc. (Specify)				Oily or You	n, State)	
completely filled in	edical	29a. Certifier 1 Cartifying (Check only 2 Medical E	Physician: To the be xaminer: On the basis	of examination	edge, death and/or inv	occurred at the twestigation, in my	me, date and place, opinion, death occur	and due to the d red at the time, d	cause(s) and mann date and place, an	ner as stated. d due to the cause(s)
	Med	one) 29b. Signature and title of certifier	and manner	stated.			se number		A 444	Month, Day, Year)
3		23b. Signature and time of continue.)	1201	20	0.	C.M.E.		January	9, 2004
5		30 Name and address of person w	tho completed cause of	of death (Item 23	3a) (Турв,	Print) 111 P.	nn Charact	- Dal4-	mara Mar	mrland 21201
-	1									
pere		PATRICIA A	32. Regi	SLLAK	ME		am street	., Daren	nore, ra	ryland 21201

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

/M Exa

Fune Direc

Physici /Medi Examir

To the Hospital or Attending Phyaician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the inversal director, page 2 should be detected for use as the burita-fransit Division of Vital Records, P.O. Box 68760,

	•	1 - For Stete Registrar	State of Maryland		tificate of L			eg. No. 200	00502
oioio		Decedent's Name (First, Middle, Last) A	\ 1				2. Date of Dear	-	3. Time of Death
sicia edica	ıl.	James A.	Daniel 5				Jan.	7, 20	04 412 Pm
mine	r	4a. Facility Name (If not institution, give s	street and number)	_	4b. City, Town, or	140		4c. County of De	ath
		5. Social Security Number 6. Sex	7. Age (In yrs. las	t hinthday)	If Under 1 Year	If Under 24 Hrs		MA	irthologo (State or Foreign
ral tor			IM 2□F 63	Yrs.	Months Days	Hours Min.		Year)	irthplace (State or Foreign Country) and
		10a. State 10b. County	10c. City,	Town or Loc	cation				10d. Inside City Limits
	ç	Md N/	7 /3a	1/im	ore				1. ⊠ Yes 2 □ No
	Funeral Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What (Country?
	a l	2821 USWLGO 11. Marital Status	12. Was Decedent Ever in U.S.	12.14	212		Specific Ven es No	14. Race - Arr	g.
	Ē	1 Never Married 24 Married	Armed Forces? 1 ☐ Yes 2	1	Vas Decedent of Hi Yes, specify Cuba		to Rican, etc.)	Black, Wh	nite, etc.
١.	≥∣	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	_ 1	☐ Yes 2 7 5 No	Specify:		Specify:	lack
	Completed	15. Decedent's Educ (Specify only highest grade	cation a completed)	16a. Deced (Give)	ent's Usual Occupa kind of work done o ONOT use retired,	tion uring most of wo	rking	16b. Kind of Busines	s/Industry
	E P	Elementary/Secondary (0-12)	College (1-4or 5+)	me. L	aborer			County	Maintenance
(BeC	17. Father's Name (First, Middle, Last)			100000		me (First, Middle, I	Maiden Sumame)	y 1 c m c m c
	9	Henry Dank	.ls			Agnes	s Koss		
		19a. Informant's Name/Relationship (Ty)	pe, Print)		Address (Street a	/	2 11	City or Town, State,	Zip Code)
	-	20a. Method of Disposition	20b. Plac	2821	ition (Name of	10 Ane		20c. Location - City o	2/S
		1 Surial 2 ☐ Cremation 3 ☐ R	emoval from State / cerr		atory or other place	1 4 1		By 11.	I I I I I I I I I I I I I I I I I I I
o i	-	* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	Loud	on PC	Name and Addres		16/2004	19/10, 10	vice P.A.
once		Callen C.	Dandan	C	Solfong C	Culloh	lass For	The second	21217
		23a. Part1. Enter the disease, or complications shock, or heart failure. List only on	cations that caused the death.	Do not ente	r the mode of dying	, such as cardiac	or respiratory arre		Approximate Interval Between
an		Immediate Cause (Final disease or condition	Myocardial	In	+archom				Onset and Death
al er		resulting in death)	Due to (or as a consequer	nce of):					
	_	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequer	nce of):	ery Uis	æse			
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
		resulting in death) Last	Due to (or as a consequer	ice of):					
	Medical		l						
		IF FEMALE:	3c. If yes, outcome of pregnance	v			-	204 Date of the	E
	cian	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat	ath 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of de Month	Day Year
	- NS	9 Unknown	9□ Unknown						
	Completed by Physician	Part II. Other significant conditions con	tributing to death but not resulting	ng in the un	derlying cause give	n in Part I.			to the cause of death?
	ered						1 □ Ye	s 2 No 3 P	
	E.						24a. Was ar autops perform	24b. Were a prior to death?	utopsy findings available completion of cause of
	5	25. Was case referred to medical	11111			26 Place of Dea	1 ☐ Yes 2	'Mo 1 ☐ Ye	
	10 De	examiner?	ospital: 1 ☐ Inpatient 218 EP	/Outpatient	3 DOA Othe			nce 6 □Other (Spe	ecify)
	5	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	b. Time of Injury	28c. Injury Work		28d. Describe ho		
	Cati	2 Accident investigation 3 Suicide 6 Could not be				es 2 No			
	ertil	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, tarm, stre	et, factory, office		City or Town	reet and Number or R , State)	lural Houte Number,
	<u>ة</u>	29a. Certifier 1 Certifying Phys	icien: To the best of my knowle	dge, death	occurred at the time	, date and place	, and due to the ca	use(s) and manner a	s stated.
1	medical Certification:	(Check only 2 Medical Examin	ter: On the basis of examination and manner stated.	and/or inv	estigation, in my op	nion, death occu	rred at the time, da	ite and place, and du	e to the cause(s)
2	2	29b. Signature and title of certifier	(X)		29c. License		29	d. Date signed (Mon	
	-	Dr. Leah h	Dendell SMD			3910		January	7,2004
		30. Name and address of person who con	mpleted cause of death (Item 23	1	rint)	Baltim	we MC	21315	
State		31. Date filed (Month, Day, Year)	32. Regular's Signature		- 1 WE.	1-311-	ne Jill	× 1415	

State

Registrar

JAN 1 3 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Yeer Month **Physician** 10:18aм GWENDOLYN DORSEY 2004 January /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimore (res) 5589 Kennison Ave If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5 Social Security Number **Funeral** 1 □ M 2 □ VE 171931 Connecticut August 72 Director 218-28-6334 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County 28e-f ehow the Medical Examiner count by notified at 1 Yes 2 No N/A Baltimore Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö 21215 U.S.A. 5589 Kennison Avenue 238 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: or Itema 11 Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black Maryland 21215-0036 à 3 Widowed 4 □ Divorced "naturel", 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education (Specify only highest grade completed) Pharmacy College (1-4or 5+) than Flementary/Secondary (0-12) is 1 and 2 should be filed with of Health and Menta! Hygiene. Item 27 is marked other than Sales Person 11th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lucelia Day Albert Waters 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 117 19a, Informant's Name/Relationship (Type, Print) 4605 Embassy Circle, #304 Owings Mills, MD Carolyn Jackson Pages 1 and Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of h Importent: if its any injury or of once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 1/12/04 Baltimore, MD 22. Name and Address of Facility HOWELL FUNERAL HOME 4600 Liberty Heights Ave, Balto., MD21207 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ENGESTIVE HEART FAILURE Immediate Cause (Final disease or condition resulting in death) Priysician /Medical OBSTRUCTIVE LUNG DISOTSE **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transi Due to (or as a consequence of): physiciar Physician/Medical The law requires that the death certificate the IF FEMALE: 9SF 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No
9 Unknown jo 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. I the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ ABRICE Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2 No or Attending Physicien: 26. Place of Death Check onli one Be 25. Was case referred to medical examiner? Other: Hospital: 4 ☐ Nursing Home 5 Hesidence 6 ☐ Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death After t Certification: 1 Natural 2 Accident 5 Pending investigation after death.

Director: Aff 1 ☐ Yes 2 ☐ No M 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours a To the Funeral D Hospital Mertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5710 78E1-WUST 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 1 3 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician ania Marie Chud.r /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northwest Hospital Center Baltimore County Randallstown If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛱 F 85 218-14-0304 Yrs. Director Jan.30 1918 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or itame 23s or 28s-f ehow the Medical Examiner must be notified at 1 □Yes 2 □ No Director Md. n/a Baltimore 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 21230 U.S.A. 201 Warren Ave. Apt. 402 Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married ☐Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No þ If Yes, Give Year or Dates: Specify: white 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 8 0 Housewife Home maker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 end 2 should be f Department of Health and Mental I Important: If item 27 is marked ot Bell Rindy Henry ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Toni Vecera (Daughter) 2110 Ganton Green A-103 Woodstock, Md. 21163 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park | 01/12/2004 Glen Burnie, Md. 22. Name and Address of Facility
McCully-Polyniak Funeral Home 21. Signature of Fungral Service Licenses A 21230 130 E. Fort Ave. Baltimore, Md. Print. Enter the disease, or complications by t caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death In mediate Cause (Final disease or condition **Physician** myoccordina /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of): Examiner and I-transil The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burial-Box 68760, the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 4 Pregnant at time of death 5 Other (specify) signed by the a Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed 20 No certificate 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this I Director: After this of in by the funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural death. 1 Tyes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a To the Funerel C To the Hospital completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) [5.cr 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registra s Signature 31. Date filed (Month, Day, Year) State 1 3 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene

		1	State Registrar	Certi	ificate of Death	Reg. N	٥.	
		_	Decedent's Name (First, Middle, Last)			Date of Death Month Date	ay Year	3. Time of Death
	Physicia	_	ANN	EPSTEIN		JANUARY 9	2004	5:20 P M
	/Medic Examin	or I	4a. Facility Name (If not institution, give street and r RUXTON OF PIKESVILLE NUF		4b. City, Town, or Location of Death BALTIMORE		c. County of Deeth	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 V		tf Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year JULY 15 1	9. Birthpl Coun 922 POLAN	lece (State or Foreign try) D
	_		Usual Residence of Decedent	10. Ch T			1	0d. Inside City Limits
	n the Maryland r 28a-f ehow	tor	MD BALTIMORE	BALTIMORE	ation			1 Yes 2 No
	with the	Direc	10e. Street and Number 7 SUDBROOK LANE		10f. Zip Code 21208	USA	citizen of What Coun	ntry?
9	be filed within 72 hours after death with the Maryland at Hygiene. Hygiene death with the "natural", or items 23a or 28a-f ehow other than "natural", or items 23a or 28a-f ehow event, the Maulical Examinar must be notified at	y Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes	s 2 No Give X 1	as Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto		14. Race - Americ Black, White, Specify: WHIT	etc.
Ö	hours tural',	ed by	3 ☐ Widowed 4 🛣 Divorced Year o	Dates:	ent's Usual Occupation	16b.	Kind of Business/Inc	dustry
21215-003	I within 72 iene. r than "na ine Madic	Completed	(Specify only highest grade complete	(Give kı life. Do HOMEMA)	ind of work done during most of work O NOT use retired) KER		HOME	
Maryland 2		To Be C	17. Father's Name (First, Middle, Last) MORDECHAI GOR		DEBORAH	e (First, Middle, Maide	POTASH	
	nd 2 sho lith and 27 is m r traum		19a. Informant's Name/Relationship (Type, Print) MRS. ROSE CAPLAN/DAUGHT		Address (Street and Number or Run REESE ROAD WESTMI			Code)
Jore,	Pages 1 and 3 nent of Health int: If item 27 iry or other tr		20a. Method of Disposition 1 Disposition 2 Cremation 3 Removal from the Control of Con	m State 20b. Place of Disposicemetery, cremit BETH TFILO	atory or other place)	Date 20c. 1,2004 W00	Location - City or To	
Baltimore,	permit. Pages Department of t Important: If ite any injury or of once.		. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Serv > Literisee	22.	Name and Address of Facility SOL	LEVINSON	& BROS. I	INC.
_	707 g d		23a. Part1. Enter the disease, or complidations th		00 REISTERSTOWN F		ILLE, MD.	Approximate
	Physician /Medical		shock, or heart failure. List only one cause of Immediate Cause (Final disease or condition and indicate in death)	PANCREAT	ic CANCE			Interval Between Onset and Death
	Examiner		Sequentially list conditions, b.	to (or as a consequence of): to (or as a consequence of):				
	cuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.					
68760,	eath certificate be executed attending physicien and for use as the burial-transit	/Medical Ex	resulting in death) Last Due	to (or as a consequence of):				
	ing pt	Med	IF FEMALE:					
O. Box	0 0	Physician/I	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delive Month	ery Day Year
ls, P.O.	res that the signed by th I be detache	þ	Part II. Other significant conditions contributing	o death but not resulting in the un	iderlying cause given in Part I.		o use contribute to to	
of Vital Records,	2 5 8	Completed				24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
Ä	The ate h page	E				performed 1 ☐ Yes 2 ☑	? death? No 1 ☐ Yes	2 No
ita	ysician: The is certificate director, pag	Be (25. Was case referred to medical examiner?			th Check only one		
Ž V	di S	2	1 ☐ Yes 2 ☑ No	☐ Inpatient 2 ☐ ER/Outpatient		ome 5 Residence		(y)
ion o	Attending Pl ir death. ector: After ti by the funera	ation:	27. Manner of Death Natural 5 Pending 2 Accident investigation	ate of Injury 28b. Time of Injury Injury	28c. Injury at Work? M 1 Yes 2 No	28d. Describe how in	Jury occurred	
Division	after deg	Certification:		ace of Injury - At home, farm, stre uilding, etc. <i>(Specify)</i>	eet, factory, office	28f. Location (Street City or Town, St		al Route Number,
K	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	(Check only 2 Medical Examiner: On the	the best of my knowledge, death the basis of examination and/or invitation stated.	roccurred at the time, date and place restigation, in my opinion, death occu	, and due to the cauce rred at the time, date a	(c) and manner as a and place, and due t	stated to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	00140445	29c. License number		Date signed (Month,	
	3		30. Name and address of person who completed	cause of death (Item 23a) (Type)		AVE B	SALD M	1) 24208
	St Regist	ate	31. Date filed (Month, Day, Year)	2. Registrar's Signature	E .			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death January 7 2004 Harry Cory Felter **Physician** 1110 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Carroll Hospital Center Westminster Carroll ff Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2□ F 93 unknown Yrs. Feb 19 1910 Director Pa Usuel Residence of Decedent 10a. State 10b. County show 10c. City, Town or Location 10d. fnside City Limits ir than "natural", or items 23a or 28a-f shov Md Carroll Marriottsville 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7900 Ridge Road 21104 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No ff Yes, Give X Year or Dates: 1 ☐ Yes 2 No Specify: Specify: white 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) sales representative Nabisco Corp. permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygie Important: If them 27 is marked other any injury or other traumatic event, It 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Harvey Felter Illona Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kurt Cassell (grandson) 7900 Ridge Rd., Marriottsville, Md 21104 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) All County Cremation | 1-13-04 Sykesville, Md 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Haight Funeral Home & Chapel Chiquestaight sterbert P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Finaf disease or condition resulting in death) ARTORIOSCIULITIC CARDIOVASCUCAR **Physician** YEARS /Medical Due to (or as a consequence of): Examiner YONK> 1ABETES Morcitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and hed for use as the burial-transit Due to (or as a consequence of): the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregrant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Day 4 Pregnant at time of death 5 Other (specify) detached ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 this certificate has autopsy performed 1 ☐ Yes 2 🖳 No After this certification funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Thipatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. injury at Work? 28d. Describe how injury occurred Certification: Attending 1 Natural 5 Pending the nospine.

Inin 24 hours after death.

Ithe Funeral Director: Aft. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ò the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 29b. Signature 5 and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) au sus 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PATRICK 1URNUS ELDORIAURS M) 21784 1000 Suite

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 1 3 2004

21215-0036

Baltimore, Maryland

P.O. Box 68760,

Division of Vital Records,

32, Registrar's Signature

			For State	State of Maryla	nd / Dep	artment of	Health and			_	3 1 10
			- State Registrar		Ce	rtificate o	f Death		Reg. No		4 0001
			1. Decedent's Name (First, Middle, La.	st)				2. Date of D			3. Time of Death
	Physici		Victor	Fazeka.	5			Month	Cy 9	2004	1.35 AM
).	/Medic		4a. Facility Name (If not institution, giv			4b. City. Town	, or Location of Dea	th	/ 40	. County of De	ath
	Examin	er	Carroll Hospi				estminst			Car	
			Social Security Number 6. S		. last birthday)		ar If Under 24 Hrs		irth		
	Funeral			XM 2□ F 77	Yrs.	Months Day			4 19	26 4	irthplace (Stete or Foreign Country)
	Director	}	Usual Residence of Decedent					riai Cii	4 19	20 πι	ingary
	pu	}	10a. State 10b. County	10c. C	ity, Town or Lo	ocation					10d. Inside City Limits
	aryline eho	7	Md Carro	11	Sy	kesville	9				1 X Yes 2 No
	8a-f	Director									
	ith ti	Oir	10e. Street and Number 710 Obrecht Ro	ا		10f. Zip Code			-	tizen of Whal (Country?
\sim	within 72 hours after death with the Maryland ene. then "natural", or Itams 23a or 28a-f ehow fra Medical Evertiret frust be trollind at	2	710 Objectit Ro.	4U		21784	4			USA	
+	des E	Funeral	11. Marital Status	12. Was Decedent Ever in the Armed Forces?	U.S. 13.	Was Decedent of	of Hispanic Origin? (uban, Mexican, Pue	Specify Yes or N	0-	14. Race - Am Black, Wh	nerican Indian,
9	or It	T.	1 Never Married 2 Married	Armed Forces? 15 Yes 2 No Vi∈ VYes, Give	Luam	1 Yes 2 XN		, , ,			
33 17	e Fig.	by	3 Widowed 4 □ Divorced	Year or Dates:	100	TIL THIS ZUAN	о эрвену.			Specify: W	iite
10 G	2 hc	Completed	15. Decedent's En (Specify only highest gra	ducation	16a. Dece	dent's Usual Occ	cupation ne during most of wo ired)	netine	16b. k	(ind of Busines	s/Industry
7 ===	Med 7	pie	Elementary/Secondary (0-12)					Jikilig	me	dicine	
大岩	T Sign	ПО	Lionomary coochary (o 12)	College (1-4or 5+)	med	ical do	ctor			410110	
7 0	filed Hygi other		17. Father's Name (First, Middle, Last,		,		18. Mother's Na	ıme (First, Middle	e, Maidei	Sumame)	
an	d be antal	o Be	Gyozo Fazekas				Zsofia	Hegley			
3	should Ind Men	2	19a, Informant's Name/Relationship (Tyne Print)	19h Maili	ng Address /Stre	et and Number or F	Tural Boute Numi	her City	or Town State	Zin Code)
A + A + C = K Maryland 21215-0036	ges 1 and 2 should t of Health and Mer If item 27 le marks or other traumatic		Clifford Lockyer				lls, Colu				2.0000)
Our	1 and 1 and 1 and 2 and 2 ther		20a. Method of Disposition	20h	Place of Disp	nsition (Name of	-	Date	200 1	ocation - City o	Tour State
4-5	Pages nent of H int: If its iry or of		1 X Burial 2 ☐ Cremation 3 ☐			matory or other p	olace)		1	•	
/ バナク Baltimore,	Pa men ury		* 4 ☐ Donation 5 ☐ Other (Specif	y) Pa		Cemeter		3-04		kville,	
alt	permit. Departr Imports sny Inji		21. Signature of Funeral Service Lice	isee /	2	2. Name and Add	dress of Facility Ha	aight Fu	nera	1 Home	& Chapel
≥ m	8 9 E 2 9		Duan o	2. Aleust	P	.O. Box	195 Sykes	sville,	Md 2	1784	•
-	4		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea	ath. Do not en	ter the mode of a	tying, such as cardia	c or respiratory	arrøst,		Approximate Interval Between
	Dharistan		Immediate Cause (Final	one cause on each line.							Onset and Death
	Physician /Medical		disease or condition resulting in death)	a		Sumonia	3—				1 yall
	Examiner			Due to (or as a conse	equence of):						
		1	Sequentially list conditions,	b. Due to (or as a conse							
h	D =	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equence or):						
1,	te be executed ysician and e burial-transit	ап	that initiated events resulting in death) Last	c							
Ö,	ian a		resulting in death, 2231	Due to (or as a conse	equence of):						
3760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	icai		d							
39	death certificate is attending physicate is for use as the total for use	led				· · · · · · · · · · · · · · · · · · ·			-		
ŏ	n cer	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr	nancy	⊒Ectopic pregnar				23d. Date of d	elivery
00	deatle atte	cia	in the past 12 months? 1 □ Yes 2 □ No	4 Pregnant at time of		☐ Other (specify)				Month	Day Year
0	the y the	ys	9 🗆 Unknown	9□ Unknown							
ص ّ	uires that the de i signed by the a id be detached f	by Physician/Medi	Part II. Other significant conditions	ontributing to death but not re	sulting in the u	inderlying cause	given in Part I.	23e. Did	tobacco	use contribute	to the cause of death?
ds	sign d be		New	onset Sa	17ure	Disord	er	1 🗆	Yes 2	□ No 3□	Probably 4 Donknown
Ö	w requir been si should	Completed								1	
ec	law last	Idu						24a. Wa auto	s an opsy form <i>e</i> d?	24b. Were a	autopsy findings available ocompletion of cause of
	The law cate has page 2:	50						1 ☐ Yes		death?	s 2 No
ta	tician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?				26. Place of De	eath (Check only	one)		
2	S D	To	1 Yes, 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 DOA	Other: 4 Nursing	Home 5 ☐ Res	sidence	6 Other (Sp	ecify)
0	9 Ph er th eral		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. in	jury at	28d. Describe	how inju	iry occurred	
0	th. Aft.	ţ	1 Natural 5 Pending 2 Accident investigatio		Injury		York? □Yes 2□No				
is.	dea dea ctor	fice	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of Injury - At	home, farm, st	reet, factory, offic	00	28f. Location	(Street a	nd Number or I	Rural Route Number,
Division of Vital Records, P.O. Box 68	after Dire	Certification;	4 Homicide	building, elc. (Spec	cify)	,,		City or To			
_	pita ours eral filled		29a. Certifier 1 Certifying Pl	nysician: To the best of my kr	nowledge des	th occurred at the	time data and at-	and due to the	0.02::::-/:) and mass s	as stated
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only 2 Medical Example)	niner: On the basis of examin	nation and/or in	nvestigation, in m	y opinion, death occ	curred at the time	, date an	d place, and di	ie to the cause(s)
	thin the	Mec		and manner stated.		200 1:00	ense number		204 D	le signed /l/s	oth Day Year!
	L M L		29b. Signature and title of certifier	oun pell				>		ate signed (Moi	
				J. N	16	D	199200	2	200	wery.	9, 2004
	1()		30. Name and address of person who	completed cause of death (Ite	em 23a) (Type	, Print)					
			John C. Abel,	M.O. 295	Stone	er Ave.	Suite	301 V	N524	minste	MD 21157
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature						
	Regist	rar	JAN 1 3 200	1 60 2	1	40					

DHMH 17 Rev 1/2001

ORIGINAL

			1_ For State	State of Ma		d / Depa	artmer	nt of He	ealth and	Mental Hy		egible.	0.000
			Registrar			Cei	rtifica	te of D	Death		Reg. No.	ZUUL	+ 00508
н	Physici	an	Decedent's Name (First, Middle, Las	t)						2. Date of De Month	Day		3. Time of Death
	/Medic	al	VERNON MORRIS FAII				4. 65	-		JANUAR		2004	5:45 A. M
	Examin	er	4a. Facility Name (If not institution, give	· ·	г				Location of Deal	tn		County of Dea	th
	Funeral		5. Social Security Number 6. Se	7. Aq		last birthday)		ESVIL r 1 Year	L上 If Under 24 Hrs		th.	RROLL 9. Bird	tholace (State or Foreign
	Funeral Director		212-10-1330	Ж м 2□ F		6 Yrs.	Months	Days	Hours Min	SEP. 6	ıy, Year)	O7 MAR	thplace (State or Foreign buntry) CYLAND
	ъ.		Usual Residence of Decedent								,		
	arylar show	_	10a. State 10b. County			y, Town or Lo							10d. Inside City Limits XXX Yes 2 ☐ No
	Be-f	Director	MARYLAND CARROLL 10e. Street and Number		SYK	ESVILL							1
	with the or s	ă						p Code		ĺ	UNIT	ten of What Co	ES
	72 hours after death with the Maryland Ineturel', or Items 23a or 286-f show dital Examinat must be notified at	Funeral	7309 2nd AVENUE	12. Was Decedent	Ever in U.	.S. 13. 1		784 Ident of His	panic Origin? (9			MERICA 4. Race - Ame	erican Indian.
က	or iten	표	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 22☐N		i i		3737		Specify Yes or No to Rican, etc.)		Black, Whit	
සු	rei', a	ğ	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:			1 🗌 Yes	2421 No	Specify:			Specify: WHI	TE
21215-0036	72 h	Completed by	15. Decedent's Ed (Specify only highest grad			16a. Deced	dent's Usu kind of wo	al Occupat	tion uring most of wa	rking	16b. Kin	d of Business	
12	within ene. then "	m ld	Elementary/Secondary (0-12)	College (1-4or 5	5+)							RVISOR	****
22	Hygie Hygie ther t		17. Father's Name (First, Middle, Last)	4		AC	COUN'		18 Mother's Na	me (First, Middle		JNTS PA	YABLE
an	d be	o Be	JOHN W. FAID							LOUISA E		A 1-2-5	
Maryland	should be nd Mental marked umatic ev	2	19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailir	ng Addres			ural Route Numb			Zip Code)
	od 2 Ilth a 27 is r tra		BARBARA HOFFMAN (1	DAUGHTER)		9323	TULS	EMERE	ROAD;	RANDALL	STOW	N. MARY	LAND 21133
Baltimore,	of Heal		20a. Method of Disposition		20b. P	lace of Dispo	sition (Na	me of		Date		ation - City or	
Ĕ	permit. Pages 1 Department of H Importent: If ite any injury or ot		1XXBurial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify			DON PA	RK C	EMETE	RY 200	. 05, 4	BALT	IMORE.	MARYLAND
alt	Departr Departr Importe any inju		21. Signature of Funeral Service Licens	500		22	2. Name a	nd Address	of Facility LO	UDON PAR 20 WILKE	K FUI	NERAL E	IOME
<u>—</u>	89 = 9		JAMO O.CM	aung.					BA	LTIMORE,	MARY	YLAND 2	1229
			23a Ray . Enter the disease, or comp shock, or heart failure. List only of	lications that caused one cause on each li	the deatine.	h. Do not ent	er the mo	de of dying	, such as cardia	c or respiratory a	rrest,		Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	a D	en	mer	10	ï					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a conseq	uence of):							
		-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequ) / J							
	nsit	min	Cause (Disease or injury	R		al	Co	no	60				
7	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as		-				<u> </u>			
000	ate be executed hysician and the burial-transit	cai	l	d	H	F							
99		Medi	IF FEMALE:										
Вох	death certifica e attending ph id for use as th	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth			Ectopic p	regnancy			23	3d. Date of del	
	e dea the at hed fo	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at 9☐ Unknown	time of d	eath 5□	Other (s	pecify)				Month	Day Year
P.O.	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	by Physician/Med	Part II. Other significent conditions co	ontributing to death b	ut not resi	ulting in the u	nderlying (Sanse diver	n in Part I	23e Did t	obacco us	e contribute to	the cause of death?
ds,	signe d be		CR	· I			indenty in igr	addo givei			Yes 2		obably 4 Unknown
202	v requences	lete	1-1-7-1	V						24a. Was		24h Wara au	itopsy findings available
Re	he lav e has	Completed	A 10	aenia	м					autor	osy ormed?	prior to death?	completion of cause of
tal			25. Was case referred to medical	1 emil	1				26 Place of De	1 ☐ Yes ath (Check only o	2 110	1 ☐ Yes	2 □ No
<u> </u>	S 0 15	To Be	examiner?	Hospital: 1 ☐ Inpatie	nt 2	ER/Outpatien	nt 3□ D0	Othor	_	dome 5 ☐ Resi		□Other (Spe	cifv)
0	ding Phy th. After thi funeral	n:	27. Manner of Death 1 ☐ Matural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry v Year)	28b. Time of Injury	1	28c. Injury a	at	28d. Describe			
<u> </u>	Attending in death.	atic	2 Accident investigation			,	М		es 2 □ No				
Division of Vital Records,	br Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At ho c. <i>(Specif</i>)	ome, farm, str	eet, factor	y, office		28f. Location (3 City or Tox	Street and vn, State)	Number or Ru	ıral Route Number,
	pitei		29a. Certifier 1 Certifying Phy	relate - T - 1	-1 1					1			
	24 hc 24 hc Fun etely (edical	(Check only 2 Medical Exem	/sicien: To the best iner: On the basis of and manner sta	f examina	wiedge, death tion and/or inv	n occurred vestigation	at the time	nion, death occ	e, and due to the urred at the time,	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Me	29b. Signature and title of confilier					c. License				signed (Monti	
	(_		1414VC	Mei	4	IND	1	5-0	054	-218	01	-02	-2004
-	45		30. Name and address of person who o	completed cause of d	eath (Item	1 23a) (Type,	Print)						
	H		DR. Raman 1	3 Kerner	-	349	Ma	Ceil	mali	He Wes	t m	inster	-2004 MD
	Sta Registr		31. Date filed (Month, Day, Year)	32. Regist	ar's Signa	ture	Some	E.		,			

		-	For State	5	State of	Marylan	-			lealth a	and M	ental Hy		201		ye	00
			Registrar 1. Decedent's Name (First, Midd	ile (ast)			Cel	unca	e or i	Dealii	1	2. Date of De	Reg. No.	to C	9 7	3. Time of Dear	th
	Physicia		Elizabeth I	,	1+05							Month	Day	Ye			AM
	/Medic Examin		4a. Fecility Name (If not instituti			per)	1	4b. City	Town, or	r Location o	of Death	Sharra	7	County of D	eeth		
	LAdmin	Ğ.	Johns Hopkins	Bu	yview	o Medi	cal	t	Soult	timo	ore]	Baltir	nore	City	
	Funeral		5. Social Security Number	6. Sex	7.	. Age (In yrs.		If Unde Months	r 1 Year Days	If Under a	24 Hrs. Min.	8. Date of Bir (Month, De	th y, Year)	9.	Birthpla Country	ce (Stete or For	eign
	Director	-	219-18-1927 Usual Residence of Decedent	I L IW	2X1	80	Yrs.					04/08	/1923	3 <u>M</u>	[ary	and	
	and w		10a. State 10b. Count	у		10c. Cit	y, Town or Lo	ocation							100	I. Inside City Lir	nits
	Mary -1 sh	ţō	MD Ba	ltimo	re	Ki	ngsvil	le								1 □ Yes 2 🔀	No
	r 28a	Director	10e. Street and Number						p Code				10g. Citi	zen of Wha	t Country	y?	
	th with	aiD	12008 Cedar I	ane				2	1087					SA			
	ems ems	Funeral	11. Marital Status		Armed Force		.S. 13.	Was Dece	dent of H	lispanic Orig	gin? (Spe i, Puerto l	cify Yes or No Rican, etc.))-	S A 14. Race - / Bleck, V			
36	or It	by Fu	1 ☐ Never Married 2 ☐ Married 2 ☐ Married 2 ☐ Midowed 4 ☐ Divorce	- 1	1 Tes 2 If Yes, Give Year or Dat	XNo		1 🗆 Yes	2 X No	Specify:				Specify:	.TL L		
21215-0036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene ortant: If item 27 is marked other than *natural', or Items 23e or 28e-f show ortant: If item 27 is marked other than *natural', or Items 25e or 28e-f show injury or other traumatic sysnt, the Medical Examine trial be mullified at injury or other traumatic sysnt, the Medical Examine trial be mullified at 8.	ed b		nt's Educat		es.	16a, Dece	dent's Usi	al Occup	ation			16b. Ki	nd of Busin	White ess/Indu	-	
15	n na	Completed	(Specify only high Elementary/Secondary (0-12)			10r 5+)	(Give	kind of w	ork done i use retired	during most d)	t of workii	ng					
212	d with	E	12		College (1	+0, 3+)	Ada	inis	trati	ive Sa	ecret	ary	M	artin	Co.		
	be filed ital Hygi od other svsnt, I	Be	17. Father's Name (First, Middle	, Last)						18. Mothe	er's Name	(First, Middle	, Maiden	Sumame)			
yla	2 should be and Mental is marked is umaric sv	2	William F. B									eeland					
Maryland	2 shot and is m		19a. Informant's Name/Relation					1				i Route Numb		r Town, Sta	te, Zip C	ode)	
	1 and Health Im 27 Ther t		Frank B. Ful	ton (.	husban		12008 ace of Dispo			ane -		sville		21(cation - City		n. State	
ية	Pages nent of h ant: If its ury or o		1 Burial 2 Cremation		noval from St	tate	cemetery, cre	matory`or	other plac		\a /a =	10004					
Baltimore,	permit. Page Department of Important: If any injury or ance.		' 4 □ Donation 5 □ Other 21. Signature of Funeral Service		-	H1										aryland Home, P	
Ba	permit. Departrimportrimports sny injugan		JE SUC	Kass	elmi							Kings				087	.д.
£.5	Ça		23a. Part1. Enter the disease, shock, or heart failure. Li	or complica	tions that car	used the deal									F	oproximate)
	Physician	0	Immediate Cause (Final disease or condition	st only one	6	2000	aru	Av	ton.	Di	100	10				Onset and Deat	1
	/Medical		resulting in death)	C a.	Due to (o	r as a consec	luence (t):		J		36-1	, C					
	Examiner	L	Sequentially list conditions,	b.													
1	pe isi	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	₹	Due to (o	r as a consec	(uence of):										
· V	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	C	Due to (o	r as a consec	quence of):								+		-
760	ysician ysician	calE															
68	ifficate g phy as the	edi															
Box	eath certificat attending phy I for use as th	M/us	IF FEMALE: 23b. Was decedent pregnant	230		ome of pregn		□Ectopic:	oregnancy	,				23d. Date of	,		
. B	e deal	Physician/M	in the past 12 months? 1 □ Yes 2 ○ No		4☐Pregna 9☐ Unknov	nt at time of o	death 5	Other (s	specify) _					Month	L	ay Year	
P.O.	that the de led by the a detached t		9 ☐ Unknown Part II. Other significant cond	tions conto	buting to dea	ath but not res	sulting in the I	ınderbina	Called UIV	en in Part I		23a. Did	tobacco u	se contribu	te to the	cause of death	1?
	S	l by	CVA		ibating to do		January III III I		oudoo g					_		oly 4 🗆 Unkn	
Sor	w require been si should I	etec	COPD			, , , , , , , , , , , , , , , , , , , ,			· · · · · · · · · · · · · · · · · · ·			24a. Was	an	24h Wer	e autons	sy findings avai	lable
Vital Records,	The lay	Completed	(01)									auto	psy ormed?	prio	r to comp th?	pletion of cause	of
tal		e Co	25. Was case referred to medi	al						26 Place	of Death	1 Yes	2X No	1 1 1	Yes 2	□ No	
>	Physician: this certificantal director,	0 B	examiner? 1 ☐ Yes 2 🕱 No	_	spital:	patient 2] ER/Outpatie	nt 3 🗆 🖸	Oth	000		me 5□Res		6 Other (Specify)		
Jοι		n: T	27. Menner of Death 1 Natural 5 ☐ Pen	tina	28a. Date of	Injury Day Year)	28b. Time o	of	28c. Injur Wor			28d. Describe	how injur	y occurred			
Sion	ttendir death. ctor: Af y the fu	atic	2 ☐ Accident inve	stigation				М	1 🗆	Yes 2	No						
Division	or Attendated of Director:	Certification:		mined	28e. Place o buildin	of Injury - At h g, etc. (Speci	iome, farm, st	reet, facto	ry, office			28f. Location (City or To			or Rural I	Route Number,	
	ospitei or A hours after unerel Dire		29a. Certifier 1 Certif	ing Physic	rien: To the i	hast of my kn	owledge dea	th occurre	d at the tir	me date an	d place	and due to the	nausa(s)	and manne	ar ae etai	ted.	
	I 4 L O	edical	(Check only 2 Medic	al Examine	r: On the ba	sis of examina	ation and/or in	rvestigatio	n, in my	ppinion, dea	th occurr	ed at the time	date and	place, and	due to t	he cause(s)	
	To the within 2 To the comple	Me	29b. Signature and title of cert		-	~				se number				e signed (A			
			Rachell	2.6	~	1,1	wo		056	570	5		Jan	часч	8+1	, 200	4
	in		30. Name and address of pers	on who com	pleted cause	of death (Ite	m 23a) (Type	, Print)								no 212	
	10		RACHELLE G	AJA	DHAR	5505 gistrar's Sign	HOPA	cinz	BAYI	VIEW (CIRCT	LE, BA	4 LT,	MOR	E /	no 212	24
1	St Regist	ate rar	31. Date filed (Month, Day, Ye	ar)	2. Re	egistrar's Sign	ature	181				,					
			108113	/ 111114	B 3/8 1937 A 1	THE A PLAN	The state of the s	The state of the s									

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Helen Louise Faulkner 1:15 A.M 2004 January /Medical 4c. County of Death 4b. City. Town, or Location of Death 4e. Fecility Name (If not institution, give street and number) Examiner Baltimore 2701 Norfen Road Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Oct. 2, 19 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 □ M 2 1 F 217 34 3307 66 Yrs 1937 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral', or Items 23a or 28a-f show Examiner must be notified at 1 Yes 2X No Baltimore Director Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 2701 Norfen Road 21227 Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filled within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 ie marked other then "natural, or item any injury or other traumatic event, the Modical Experiment ADCE. 1 ☐ Yes 212 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Ferndale Comm. Club Bar Maid 8th 18. Mother's Name (First, Middle, Meiden Sumame) 17. Father's Name (First, Middle, Last) Be Michael Sadler Anna Jacobs ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) / Husband 2701 Norfen Road Baltimore, Maryland 21227 Donald Faulkner 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Park 1/14/2004 Elkridge, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilities J. Gonce Funeral Home, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 Approximate Interval Between on set and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) Metastatic Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine certificate be executed ed by the attending physician and detached for use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box (IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown cate has been sig. . page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 2∯ No 1 Yes 25No funeral director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Alter Natural 2 Accident 5 Pending 1 Yes 2 No death. investigation after death Director: / the 1 28f. Location (Street end Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 Homicide ō within 24 hours at To the Funerel D completely filled i Hospital TEL Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29d. Date signed (Month, Dev. Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SANC 32. Registr#'s Signature 31. Date filed (Month, Day, Year) State JAN 1 3 2004 > Registrar

			For	State of Maryla		artment of I		•	giene	9.DIC.	~ ~ ~
		•	1 - State Registrar		Cei	rtificate of	Death		Reg. No.	JUL	UUDII
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Dorothy Joyce Gi	.bson				2. Date of De Month	ath Day	2004	3. Time of Death
	Examin		4e. Fecility Name (If not institution, give so Union Memorial Hos	treet and number) spital		4b. City, Town, Balt	or Location of De LMOTE	,	/	nty of Deeth N/A	
4	Funeral Director		5. Social Security Number 230-01-3186 6. Sex	M 200 F 81	s. last birthday) Yrs.	If Under 1 Year Months Days		lrs. 8. Date of Bir in. (Month, Da June (y, Year) 1922	9. Birthp Cour Penr	elece (State or Foreign http:) nsylvania
	ryland thow		Usual Residence of Decedent 10a. State 10b. County Maryland N/A	10c. (City, Town or Lo Baltin				-		0d. Inside City Limits XX Yes 2 □ No
	he Ma 28a-f	ecto	10e, Street and Number		Darci	10f. Zip Code			10g. Citizen	of What Cour	
	th with	ai Dir	3535 Hickory Avenue				21211		-	SA	,
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f ahow any injury or other traumatic event, the Madical Exemples must be rightled at ODGE.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 225 No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cub 1 ☐ Yes ※XX No		(Specify Yes or No erto Rican, etc.)	- 14. F E Spe	lace - Americ llack, White, cify: Whi	etc.
Maryland 21215-0036	hin 72 ho in "natur Madicel I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of v	working	16b. Kind of	Business/In	dustry
7	ygiene ygiene her the	Com	10		Fact	tory Wor	cer	Name (First, Middle	Envelo		ectory
and	d be fill	To Be	17. Father's Name (First, Middle, Last) Charles H. Yowell				Eva J		perman		
aryl	shoul and Me s mark	ř	19a. Informant's Name/Relationship (Typ	oe, Print)			t and Number or	Rural Route Numb	er, City or Tox	vn, State, Zip	
	l and 2 Health im 27 Iher tra		Lynn Friend Gran 20a. Method of Disposition	ddaughter		5 Hickory osition (Name of	y Avenue	Baltimo		ryLand on - City or To	
Baltimore,	Pages ment of Hant: If its		1 Burial 2 □ Cremation 3 □ Re '4 □ Donation 5 □ Other (Specify)	emoval from State	ake Viev	Memoria		12/2004	Sykesv	ille,	Maryland
Balt	permit. Depart Import any in		21. Sign of e of Funeral Service-Licens	Henss	36	631 Falls	Road.	z Funeral Baltimore	- Marv	Inc.	21211
			23a. Pany. Enter the disease, or complice shock, or heart failure. List only on		ath. Do not en	ter the mode of dy	ing, such as card	liac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cons		rdium	Johnty				10 years
ì	Examiner	_	Sequentially list conditions, b								
	ned Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a cons	equence or):						
,09/	be executed ician and burial-transit		that initiated events consulting in death) Last	Due to (or as a cons	equence of):						
6876	ficate b physic s the b	edicai	d								
Box	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	by Physician/Med	in the past 12 months? 1 Yes 2 No	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death 3	□Ectopic pregnanc □ Other (specify)	су			Date of delive Month	ery Day Year
P.0	that the ed by t detach	Phy	9 ☐ Unknown Part II. Other significant conditions con	tributing to death but not r	esulting in the u	inderlying cause g	iven in Part I.	23e. Did t	obacco use c	ontribute to the	ne cause of death?
rds,	quires that on signed I old be det	ed by						_ 1 🗆	Yes 2 No	3 ☐ Prob	pably 4 Unknown
Records,	e law requii has been s je 2 should	Completed						24a. Was	DSV	prior to co	psy findings available mpletion of cause of
al	ate pag	e Cor	25. Was case referred to medical				Of Diagonal	1 Yes	2 No	death? 1 Yes	2[2No
f Vital	physician: this certific al director,	To Be	examiner?	ospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 DOA	thos	Death <i>(Check only o</i> g Home 5 ☐ Resi		Other (Specif	y)
ion of			27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	W	ury at ork?]Yes 2 ☐ No	28d. Describe	how injury occ	curred	
Division	o Hospital or Attendin 24 hours after death. 9 Funeral Director: Aft etely filled in by the fur	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - Al building, etc. (Spe		reet, factory, office		28f. Location (City or To		mber or Rura	I Route Number,
	To the Hospital or Attending i within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sicien: To the best of my keer: On the basis of examinand manner stated.	nowledge, deat ination and/or in	th occurred at the livestigation, in my	time, date and pla opinion, death o	ace, and due to the ccurred at the time,	cause(s) and date and plac	manner as s	tated. the cause(s)
	To the l within 2 To the l complet	Me	29b. Signature and title of certifier	/			ise number	C111	29d. Date sig	ned (Month,	Day, Year)
			> June Ju	m MI	>	41	2438 heel D	746	Junua	my 8,	2004
			30. Name and address of person who co		16m 23a) (Type, Bulhuy		21215	CUCEL			
		ate	31. Date filed (Month, Day, Year)	32. Registrar's Sig	mature	prese	,				
	Regist	rar		and a second		St. Co.					

			1- State State of Maryland / De Registrar	epartment of Health and N Certificate of Death	fental Hygie		00512
			Decedent's Neme (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici /Medio		JEWEL A GOTSCI	TALL	Month	Day Year	04115AM
1	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	1
			HCGH	Columbia, M.		Howard	3
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birth Co. Mary	place (State or Foreign intry) land
	and and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of	r Location		1	10d. Inside City Limits
	Many i sh	ō	MD Howard	Mt. Airy			1 ☐ Yes 2 📆 No
	1 the	Director	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Cou	intry?
	h with	0	17262 Hardy Road	21771		U.S.	Α.
	deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Amer Black, White	can Indian,
۵	or Ite		1 ☐ Never Married 2 🕅 Married 1 ☐ Yes 2 📆 No	1 ☐ Yes 2 ☑ No Specify:	riicari, etc./	Specify: Wh:	
Š	ural',	d by	3 Widowed 4 Divorced Year or Dates:				
1215-0036	d within 72 hours after death with the Marylar piens piens natural; or Items 23a or 28a-1 show the Modeal Examiner must be notified at	Completed	(Specify only highest grade completed) (C	ecedent's Usual Occupation Give kind of work done during most of work fe. DO NOT use retired)	ing 16t	b. Kind of Business/Ir	ndustry
7	withir ane. then	E D	Elementary/Secondary (0-12) College (1-4or 5+)	Teller Manager		Donles	
7 0	be filed tal Hygi d other svant. I		17. Father's Name (First, Middle, Last)		e (First, Middle, Mai	Banking den Sumame)	
Maryland 2		To Be	James Leonard Parkent	Marion	Upman		
2	S D E E) —		ailing Address (Street and Number or Run	al Route Number, C		o Code)
	12 h a 7 h		Mr. John C. Gotschall (Spouse) 172	62 Hardy Road Mt. A	iry, MD 2	1771	
e,	of Healt Nem 2 Nem 2		cemetery.	crematory or other place)		. Location - City or T	own, State
Ĕ	Pages nent of int: If It iny or o		1 Burial 2 Cremation 3 Removal from State crestla	wn Mem. Gardens 1/1	6/04 Ma	rriottsvi	lle, MD
Baltimore,	permit. Pages Department of t Important: If It any injury or o		21. Signature of Funeral Service Licensee Buan L. Harst	22 Name and Address of Facility HAIGHT FUNERAL HOM Sykesville, MD 217	E & CHAPE	L, PA (Box	195)
Ą	=3		23a. Part1. Enter the disease, or complications that aused the death. Do not shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	= Physician		Immediate Cause (Final disease or condition	Shoot			Onset and Death
. 3	/Medical		resulting in death) Due to (or as a consequence of)	1. 0			
	Examiner		Sequentially list conditions, b.	aton their	~cn.5		
1	D 4≅	iner	if any, leading to immediate				
	ecute and trans	Examine	Cause (Disease or injury that initiated events c				
SC,	ate be executed hysicien and the burial-transit		Due to (or as a consequence of).				
9/8	certificate be executed nding physicien and use as the burial-transit	dicai	d				
×	leath certific attending p	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy				
ROX	ath or u	ian	in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliv Month	ery Day Year
o.	0 0 0	ysic	1 Yes 2 No 9 Unknown 9 Unknown	J Cities (specify)			
J.	requires that the een signed by th hould be detache		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobac	co use contribute to t	he cause of death?
rds,	quires n sigr ald be	d by	Ling Cancer		1√ Yes	2 □ No 3 □ Pro	pably 4 Unknown
Ö	> 42 10	jete	\mathcal{O}		24a. Was an	24b. Were auto	opsy findings available
Vital Record	e T e	ompieted			autopsy performed	prior to co	mpletion of cause of
ā	ician: Th certificate ector, pag	e C	25. Was case referred to medical	26 Place of Deatl	1 ☐ Yes 2人 1 (Check only one)	No 1 ☐ Yes	20XN0
	Physician: this certific ral director,	OB	examiner? 1 Yes 2 No Hospital: 1 Latient 2 ER/Outpa	Othor		e 6 □Other (Speci	(v)
	ding Ph h. After th funeral	n: T	27. Manner of Death 1. Netural 5 □ Pending (Month, Day Year) Injury (Month, Day Year)	e of 28c. Injury at	28d. Describe how i		,,
<u> </u>	Attending in death. sctor: After by the funer	atic	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
Division	al or Atteno after death Director:	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Stree City or Town, S	t and Number or Run tate)	al Route Number,
	To the Hospital or within 24 hours after To the Funeral Direct completely filled in th	edical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, d 2 Medicel Exeminer: On the basis of examination and/c and manner stated.	eath occurred at the time, date and place, or investigation, in my opinion, death occurr	and due to the cause ed at the time, date	e(s) and manner as s and place, and due t	stated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and Litle of certifier	29c. License number	29d.	Date signed (Month,	Day, Year)
	1		Aberois MI)	MAX 12005/81	30	1111104	
F			30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print)		1: 15	
			Scott KABEREGG, MD, MPH	600 N Wolfes	st Bul	timore	, MD 2120
	Sta Registr		31. Date filed (Month, Day, Year) 1014	whi.	-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State of Maryland / Department of Health and Mental Hygiene Registrer

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Rec. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 12:30a^M Green Sr. January 7 2004 David /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Millennium Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**X** M 2□ F SĆ Director 248-18-6842 90 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or itams 23s or 28s-1 show other traumatic event, the Modical Examinar must be notified at 1 Yes 2 No Director NA MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21223 U.S.A. 1217 West Fayette Ave Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after 0 bepartment of Health and Menial Hygiene. Importent: If item 27 is marked other than "natural", or item any injury or other traumatic avent, the Medical Examinations. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: Black Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry David Tire Shop Elementary/Secondary (0-12) College (1-4or 5+) 10th grade Owner na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Annie Mae McDonald Sylvester Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 Yale Street, Hempstead, NY 11550
ace of Disposition (Name of Date 20c. Location - City or Town David Green Jr.-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. 1/16/04 Owings Mills, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 21215 4300 Wabash Ave, Baltimore Md 23a. Part1. Enter ne disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, fary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner use as the burial-transit and Due to (or as a consequence of): attending physician Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 218 No 1 ☐ Yes 1 Yes 25. Was case referred to medical examiner? filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: A Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 2 00 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director; 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funerel Direct 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier Allasol JANUARY DO 580 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BATIMORE CEASAL N. EVIAW STREET, STE 308, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 3 2004

DHMH 17 Rev 1/2001

Registrar

deeth with the Maryland

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed

To the Hospital or Attending Physician:

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For Amend Item29d per DVR, 01/13/04dhb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** CSM Milton Gerald Giltz (USA Ret.) 2004 lanuary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Bel Air Upper Chesapeake Medical Center If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1☑M 2□F 218-07-4622 82 Director Apr. 21. Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State the Medical Examiner must be notified at Harford Edgewood 1 Yes 2 No Maryland Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21040 2219 Perry Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2₺ No Specify: White Specify: Be Completed by 3₺ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Military U.S. Government wing 2 should be file cupariment of Health and Mental Hyg Importent: If item 27 is marked other eny injury or other treumers 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Adele Oswald Hattie Gerald Andrew Giltz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela L. Santangelo/Executor 2320 Rosewood Drive, Edgewood, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition DBurial 2 ☐ Cremation 3 ☐ Removal from State 1-12-04 Baltimore National Baltimore, MD `4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 21. Signature A Funeral Service Licensee luc Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) pre **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, learning to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? 1□ Yes 2 🔍 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 29 Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 Naturai 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

o. Records,

Attending Physicien:

Show

ō

or Items 23a

Hygiene.

rsician and a burial-transit

To the Hospitel within 24 hours a To the Funeral I completely filled the Hospitel

death.

Director

Registrar

DHMH 17 Rev 1/2001

(Check only one)

29b. Signature and title of certifier

A Registrar's Signature 31. Date filed (Month, Day, Year) 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

615 W. MacPhail Rd., Bel Air, MD 21014

032299

29c. License number

29d. Date signed (Month, Day, Year)

January 8, 2004

Ö,

			For State Registrar	State of		nd / Dep	artment		and Me	ental Hygi		Û h	00516
			Decedent's Name (First, Midd	lle Last)				0. 2 0		2. Date of Death	j. 140.		3. Time of Death
	Physici /Medio	cal	MARTHA	ANN GRANT			Ab Cib. T	aum ar Lacation		Month JANUARY	Day 11, 2 4c. County	Yeer 004	4:50p M
	Examir	ner	4a. Facility Name (If not institution	_	oer)			own, or Location			4c. County		
			STELLA MAR 3 5. Social Security Number		Age (In ure	last birthday)		ALTIMOR		Date of Birth		NA 0 Birtho	lace (State or Foreign
	Funeral Director		237-38-5462 Usual Residence of Decedent	1 M 2 X F	. Age (III yis.	71 Yrs.		Days Hours		B. Date of Birth (Month, Day, 18/10/31	(ear)	Cour	NC.
	aryland show	7.	10a. State 10b. Count	4	10c. Ci	ty, Town or Lo	ocation	<u></u>				1	0d. Inside City Limits
	Ne M	Director	NC 10e. Street and Number	NA		В.	ALTIMO			10	g. Citizen of V	What Cour	
	Ne or	ă					10f. Zip (10	g. Oili2011 01 1		uy:
	8 23	rai	6122 MACBETH	I DRIVE	ant Francis I	16 12	Mas Danida	21239	rining /Snan	tu Van as Na	14 Bac	USA e - Americ	an Indian
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23s or 28s-f show raumatic event, Ite Medical Exemiter must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Ma 3 □ Widowed 4 □ Vivorce	rried 1 Tyes 2	es? ! [X No	1	was becede If Yes, specif 1 ☐ Yes 2	nt of Hispanic C y Cuban, Mexic X No Specif		can, etc.)	Specify	k, White, AFRI	etc. CAN
Maryland 21215-0036	n 72 hou natura	Completed I	15. Decede (Specify only high	nt's Education est grade completed)		16a. Dece (Give	dent's Usual kind of work DO NOT use	Occupation done during mo retired)	ost of working	7	3b. Kind of Bu	AMERT usiness/Ind	
12	withii ene. than	Щ	Elementary/Secondary (0-12)	College (1-4	for 5+)			CARE PR			СИТ	LD CA	DF
7	Hygir ther nt, I	ŏ	17. Father's Name (First, Middle	Last)		1 1	JOILK			First, Middle, Ma			<u>KL</u>
au	ntal od o	Be										-,	
Š	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 Is marke any injury or other traumatic <u>pnce.</u>	은		DWARDS		10b Maili	na Addrona /	Street and Num	BLAN		OPER	Ctata Zia	Cadal
a	l 2 st n and r ls n		19a. Informant's Name/Relation							Route Number,	6141	State, Zip	Code)
	1 and 2 Health em 27		MARISA G. HOLLO	WAY (DAUGH		6122 Place of Dispo		TH DRIV	E BAL	TIMORE.	MD 2 oc. Location -	239	Charles
0.0	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 Burial 2 □ Cremation	3 Removal from St		cemetery, cre	matory or oth	er place)	Da	10 20	c. Location -	City or 10	wn, State
altimore,	Pag ment ant: I		*4 □ Donation 5 □ Other (Specify)	CH	ARLOTT	Е МЕМО	RIAL GA	R. 1/1	7/04	CHARL	OTTE,	NC
a	permit. Departmitimporta any inju		21. Signature of Funeral Service	Licensee		2:	2. Name and	Address of Fac	ility WY	LIE FUN	ERAL H	OME P	Α
0	207 2 2			all-	_		538 N.	GIT.MOR	STREE	T BALT	IMORE.	MD.	21217
	Physician /Medical		23a. Part1. Enter the lie se, c shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	a. CEREI		CULAR			is cardiac or	respiratory arres	t,		Approximate Interval Between Onset and Death
	Examiner	er	Sequentially list conditions, if any, leading to a mediate cause. Enter Underlying	b	r as a conside	, 11							
	be executed ician and burial-transit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (o	r as a consec	quence of):						4	
8760,		cal		d									
P.O. Box 68	The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₩ No 9 □ Unknown		th 2 Feta	al death 3	⊒Ectopic pre ⊒ Other (spe				23d. Dat	e of delive nth	ry Day Year
	w requires that I been signed by should be deta	by	Part II. Other significant condit	ions contributing to dea	th but not res	sulting in the u	nderlying car	ise given in Part	t I.				e cause of death?
ecor	ne law requ has been ge 2 shoul	Completed								24a. Was an autopsy	ļ £	rior to cor	osy findings available
<u> </u>	The ate h	ő								performe		leath? □Yes	2□ No
ia	ian: artific ctor,	Be (25. Was case referred to medic	al				26. Plac	ce of Death (Check only one)	-		
f V	Physician: The la r this certificate has ral director, page 2	To	examiner? 1 ☐ Yes 2 🙀 No	Hospital: 1 🗌 Inj	oatient 2	ER/Outpatie	nt 3 DOA	Other: 4 🗆 N	Nursing Home	5 ☐ Residen	ce 6 X Oth	er (Specify	HOSPICE
Division of Vital Records,	Attending Physician: sr death. ector: After this certifice by the funeral director, p		27. Manner of Death 1 Natural 5 □ Pend	28a. Date of (Month, igation	Injury Day Year)	28b. Time o Injury	f 28	o. Injury at Work? 1 ☐ Yes 2 ☐	28	d. Describe how			III.
Divis	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could 4 Homicide deten	mined 286. Place o	f Injury - At h g, etc. <i>(Speci</i>	ome, farm, st	reet, factory,	office	28	f. Location (Stre City or Town,		er or Rura	Route Number,
2	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	edical	29a. Certifier 1X Certify (Check only one)	ing Physicien: To the b I Exeminer: On the bas and manne	is of examina	owledge, deat ation and/or in	h occurred a vestigation, i	the time, date a n my opinion, de	and place, an eath occurred	d due to the cau at the time, date	se(s) and ma e and place, a	nner as stand due to	ated. the cause(s)
	To tl Vithi. To tl	X	29b. Signature and title of certifi	er)				License number		290	I. Date signed	(Month, L	Day, Year)
	1			10-				04372	5		11	12/0	OG
_	'n		30. Name and address of person DR. TARIO M	·		m 23a) (Type,		מדי מכ	(ONTTIN)	MD 210	/	-/-	
	Sta	210	31. Date filed (Month, Day, Year		gistrar's Signa		-		TONTOM	MD 210	7.7		
785	Regist		IAN 1 3 20		مصر	19	boak	2					

DHMH 17 Rev 1/2001

JANUARY 11, 2004 4:50 p.m.

MAKTHA GRANT

			1 _ For	-	land / De	partment	of Health and I of Death	Mental Hyg	iene	ie.	00316
_			Registrar 1. Decedent's Name (First, Middle, Last)				0, 500	2. Date of Deat			3. Time of Death
	Physicia	an	DOROTH	v L	IERMAN	C	GLAZER	Month	Day Y	'ear	12:45 A M
	/Medic			·	ILKIIAN			Jan	7	704	12.73 /7 "
	Examin	ier	4a. Facility Name (If not institution, give str				own, or Location of Death		4c. County of	Death	N/A
			LEVINDALE HEBREW H				IMORE	10.0			
	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthda	Months I	Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth Month, Day, APR. 29,	1997 E	B. Birthpli Count	ace (State or Foreign (Ty) MD
auth -	Director		L17 12 7000	, -X.	88 Yrs.			APR. 29,	1915		עויי
2	>		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town or	Logation				10	d. Inside City Limits
aryla	hov #	L			,.					1	1 ☑ Yes 2 ☐ No
W W	3a-f	cto	MD N/A		BAL	.TIMORE					
돮	or 21	Director	10e. Street and Number			10f. Zip C		10	Og. Citizen of Wh		-
₹.	23a	ai	2434 W. BELVEDERE	AVENUE			21215				J.S.A.
dea	E E	Funerai	11. Marital Status	. Was Decedent Ever Armed Forces?	in U.S. 1	3. Was Deceder	nt of Hispanic Origin? (S y Cuban, Mexican, Puert	pecify Yes or No-	14. Race	America White, e	
after C	가 를 다		1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 🗖 No If Yes, Give		1 ☐ Yes 2			Specify:	***********	WHITE
3 Single	- E	l by	3 X Widowed 4 □ Divorced	Year or Dates:		10.103 24	д но ороспу.		Specity.		
2 h	ic a	tec	15. Decedent's Educa (Specify only highest grade of	tion	16a. De	cedent's Usual (Occupation done during most of wor	kina	16b. Kind of Busi	ness/Ind	ustry
A nic	Wed	pie		College (1-4or 5+)	life	e. DO NOT use	retired)	9	01.01		
V ×	gien T	Completed	Elementary/Secondary (0-12)		HON	MEMAKER			OWN I	HUME	
ITIQ X IX I 3-UU30 be filed within 72 hours after death with the Maryland	od Mental tygiene. merked other than "natural", or tleme 23s or 28s-1 ehow metic event, the Medical Examinar must be multified at	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle, M	faiden Sumame,		
g g	Mentai arked o atic eve	To B	HARRY		HERMA	NΑ	RAE			HARR	ISON
ar y id	and M	-	19a. Informant's Name/Relationship (Type	, Print)	19b. Ma	ailing Address (S	Street and Number or Ru	ral Route Number,	City or Town, Si	ate, Zip	Code)
Z 2			ROCHELLE GLAZER CO	HEN / DAU	. 120	083 LONG	G LAKE DRIVE	E - OWING	S MILLS	, MD	21117
a, <u>e</u>	of Health item 27 othar tr	1 3	20a. Method of Disposition		0b. Place of Dis	sposition (Name	of		20c. Location - C		
Pages	i Mit		1 X Burial 2 Cremation 3 Re	noval from State		rematory or oth	· · · · · · · · · · · · · · · · · · ·	1/11/04	DALTI	MODE	MD
DAILLIMO Dermit. Pages	Department of Important: If i any injury or once.		'4 □Donation 5 □Other (Specify)		ANSHE EI		AITZ CHAIM)	THE RESERVE TO A PROPERTY OF THE PARTY OF TH	BALTI		
	Depar Impor		21. Signature of Funeral Service Licensee					DL LEVINS			
u a	O 는 e q	0.0	1 Jay 17				EISTERSTOWN			_ L ,	
			23a. Part1. En er the disease, or complica shock, or heart failure. List only one	ations that caused the cause on each line.	death. Do not	enter the mode	of dying, such as cardiac	or respiratory arre	est,		Approximate Interval Between
Ph	ysician		Immediate Cause (Final disease or condition	Preum	mia						Onset and Death
	Medical		resulting in death)	Due to (or as a co						_	
E	caminer										
ω.	4	Je.	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	nsequence of):						
uted	ansit	E	cause. Enter Underlying Cause (Disease or injury that initiated events								
эхөс	n and al-tra	Examiner	resulting in death) Last	Due to (or as a co	nsequence of);						
, 60°, 60°, 60°, 60°, 60°, 60°, 60°, 60°	Sicial	cail	d.								
GOX OB/OU,	been signed by the attending physician and should be detached for use as the burial-transit		0.								
X centii	ding se a	Physician/Med	IF FEMALE: 230	c. If yes, outcome of p	regnancy				23d, Date	of daliva	2/
DOX	atter for u	iar	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 4 Pregnant at time		3 □Ectopic preg 5 □ Other (spec			Monti		Day Year
) §	the	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9☐ Unknown	o o obalii	2 - Ottier (abec	-uy/				
Ords, P.O	d by letac	Ph	Part II. Other significant conditions contri	buting to death but or	ot resulting in the	a underlying cau	rea awan in Part I	23e Did toh	acco use contrib	ute to the	e cause of death?
ທ ີ່ 8	engine pe d	by	CAO	ibating to death bat no	or resulting at the	e dilderlying cad	iso given in raiti.				ably 4 Unknown
COLOS w requires	ould ould	ted	CAU					10,16	5 ZUNU 3		ibly 4 Donknown
	2 sh	ple	Dementin					24a. Was an	24b. We	re autop	sy findings available inpletion of cause of
r e	s certificate has b irector, page 2 s	Completed	Chronic Renal	Fails	ne			perform	red? de	th? Yes	
	tifica tor, p	O	25. Was case referred to medical				26. Place of Dea	th (Check only on			
	s cert	0 8	examiner? 1 ☐ Yes 2 ☑ No	spital:	2 ER/Outpa	tient 3 DOA	0.1	ome 5 Reside		(Specify)
<u>o</u> 4	n. After this funeral di	F.	27. Manner of Death	28a. Date of Injury	28b. Time	e of 280	. Injury at	28d. Describe ho			
6 §	fr. After	to	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye	ar) Injur	y M	Work? 1 ☐ Yes 2 ☐ No				
DIVISION 1 or Attending	er death. rector: After by the funer	Certification;	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury -	At home, larm,	street, lactory,	office	281. Location (Sti	eet and Number	or Rural	Route Number,
5 5	after Dire I in b	erti	4 Homicide determined	building, etc. (S	(pecify)			City or Town	, State)		
pital	ours neral filled		29a. Certifier 1% Certifying Physic	cian: To the best of m	v knowledne d	eath occurred et	the time, date and place	and due to the on	use(s) and many	ar as etc	hated
9	Fun Fun	dicai		er: On the basis of exa	mination and/o	r investigation, in	n my opinion, death occu	rred at the time, da	ite and place, an	d due to	the cause(s)
the	within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Mec	29b. Signature and title of certifier	and mainer stated.		29c. l	License number	29	d. Date signed (Month. [Dav. Year)
7	N CO		Signature and this or continuor				56508		A.	Ø.	3001
	!			7.0				SHAO	yeun ,	', ·	evy
	b	1 3	30. Name and address of person who com	pleted cause of death	(Item 23a) (Ty	pe, Print) X/A		SHAO			
			2434 W Belveda	ave.	BALT	imore	MD 21	215			
	Sta Regista		31. Date filed (Month, Day, Year)	32/Registrar's	Signature	and .					
	TEGIST	ादा 🗀	EN 61 1 67 1114	B. 184 112 12 1	AS" AN	A TOP OF THE PARTY					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Vear 5:52PM Gallion **Physician** Darlene 2004 Tan /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Bay View Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Sept 20 1942 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2√F Days 218-42-1139 Yrs. Mo 61 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 □ No Md. Baltimore Funeral Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 21224 Baltimore U.S. A. tast 3107 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Day care College (1-4or 5+) children Elementary/Secondary (0-12) child care 12 th permit. Pages 1 and 2 should be filled w Department of Health and Mental Hygier Important: If item 27 Is marked other It, any injury or other traumatic event, tha once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Rose Ervine Heis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3107 East Homer C. triend) Shaffer Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Smithsburg Md. Smithsburg Crematory 2. Name and Address Facility FINENAL HOME 21. Signature of Funeral Service Lieensee Gary L. ROLLINS olles FREDERICK MO 21701 ranga. ST. Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Burr yourca Due to (or as a consequence of): ANDIO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> V Drail 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Los FIT 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Injury 1 Natural 5 Pending 1 🗌 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical

Physician /Medical Examiner Division of Vital Records, P.O. Box 68760 al or Attending Patter death. To the Hospital or within 24 hours aft To the Funeral Di completely filled in

the attending physician and the for use as the burial-transit

this certificate has

After t

and

or 28a-f show

the Medical Examinational be notified at

or Items 23a

'natural',

Il Hygiene.

filed within 72 hours after

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) JAN 1 3 2004

29b. Signature and title of certifier

57 32. Registrar signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

24276

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) William J. Hamm Physician January 4, 2004 8:12A /Medical 4e. Facility Name (If not institution, give street and number) 3829 Hickory Avenue 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore N/A | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | April 1 472, 957 6. Sex 12 M 2 ☐ F 9. Birtholace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Maryland 220-68-3077 46 Yrs. Director Usuel Residence of Decedent deeth with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or Items 23a or 28a-f ehow permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than *naturel', or Items 23a or 28e-1 ehow empt injury or other traumatic event, the Medical Examinar must be multilized at once. N/A MD Baltimore Xe Yes 2 □ No **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3829 Hickory Avenue 21211 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married XXMarried Specify: White Maryland 21215-0036 1 ☐ Yes XXNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
/Give kind of work done during most of working Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Truck Driver Independent College (1-4or 5+) Elementary/Secondary (0-12) 10th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Frederick Hamm Ada Hamm 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Faye Ficarro (Daughter) 3120 Rosalie Ave. Balto, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State cometery, crematory or other place)
Balto/Wash Crematory 1/6/2004 Laurel, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Balto, MD 2121 21. Signature of Fuperal Sovice Usensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MOA /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner physician and the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. as the t IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed' 1 ☐ Yes 2 ☐ No 1 Yes 2 Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Passidence 6 Other (Specify) 1 ☐ Yes 2 ☐ Mo Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral C 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medicai 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 11606(-ARNA VAIR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Park Park KATUA.S. NAIR MID 37 Strar's Signature 31. Date filed (Month, Day, Year) AN 1 3 Registrar

			For State Registrar	;	State o	of Man	yland / [rtment of He tificate of D			jiene 2	004	00319
		75	1. Decedent's Name (First, Midd	le, Last)							2. Date of Dea Month	th Day	Year	3. Time of Death
	Physicia Medic		Flora Al	berta	a :	Higgi	ns				Januar		004	11:45p M
	Examin		4a. Facility Name (If not institution			umber)		ì	4b. City, Town, or	Location of Death		4c. Cou	nty of Death	
			Manor Care -	Tows	on				Tows	on			1timo	
	Funeral		5. Social Security Number	6. Sex		7. Age (/	In yrs. last bir	thday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day	Year)	9. Birth	place (State or Foreign
	Director		345-14-8421	101	M 212 F		86	Yrs.	Working Soys		Nov 3,	1917		liana
	p.	-	Usual Residence of Decedent 10a, State 10b, County			1	0c. City, Tow	n or Lo	antion					10d. Inside City Limits
	aryla shov		10a. State 10b. County				oc. only, row	ii oi Lo	Cation					1 ☐ Yes 217 No
	8a-f	Director	Maryland Balt	imore	9		To	wso				O- Civin-	-4 \\\\\ -4 \C-1	
	or 2	100	10e. Street and Number						10f. Zip Code			10g. Citizen	or what Cou	intry?
	1 23a	<u>a</u>	509 E. Joppa R					1	21286				ISA Race - Amer	iona Indian
	termi	Funeral	11. Marital Status		Armed F		er in U.S.	13. \	Was Decedent of His f Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	Rican, etc.)		Black, White	
36	s afte		1 ☐ Never Married 2 ☐ Mai 3 ☑ Widowed 4 ☐ Divorce	9-	If Yes, G Year or				1 ☐ Yes 2 ∏ No	Specify:		Spe	ecify:	• • •
8	hour	Completed by	15. Decede			Dates.	16a	Decer	dent's Usual Occupa	tion		16b Kind o	W) f Business/li	nite
<u>5</u>	n 72 na	lete	(Specify only highe		completed			(Give	kind of work done d DO NOT use retired)	uring most of work	king			,
7	withi than	Щ	Elementary/Secondary (0-12)		-	(1-4or 5+) n/a		S	ecretary			Mi1	itarv	
0	be filed within 72 hours after deeth with the Maryland ital Hygiene. d other than "natural", or items 23e or 28e-f show event, the Medical Exertime mant be notified at	ပိ	17. Father's Name (First, Middle	Last)		11/ α				18. Mother's Nam	e (First, Middle,			
Maryland 21215-0036	Mental Arked c	8	Oosterling			Robin	son			Fan	nie		Nelso:	n
<u></u>	should nd Men s marke umatic	٦	19a. Informant's Name/Relation	ship (Type				. Mailir	ng Address (Street a					
₩	id 2 sho ith and 27 is mu traum		Linda Dietz/Da				10	1718	Lancewoo	d Road	Cockeys	71110	MD '	21030
ō,	of Health of Hem 27 i		20a. Method of Disposition	ugne	- L				sition (Name of natory or other place				on - City or T	
<u></u>	ages int of t: if i		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (moval fron	n State				-,		T 01170	1 Mar	er land
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Items 23s or 28s-1 show any njury or other traumatic event, the Medical Exercises must be notified at ance.		21. Signature of Funeral Service	7	1		Daiti		-Washingt . Name and Addres		LOLY	Laure	I, Ma	ryland
Ba	permit. Pages Department of Importent: If Its any injury or of		Bryan WOC1) [~]	LOO S	0	-	Į	emmon Fun 0 W. Pado	eral Hom	e of Du	laney	Valle D 21	Joanna.
			23a. Part1. Enter the disease, of shock, or heart ailure. Lis	-	ations that	caused th	e death. Do						21	Approximate Interval Between
		. 1	Immediate Cause (Final	t only one	a cause on	each line.								Onset and Death
	Physician /Medical		disease or cond ton resulting in death)	_ a.	Dunt	Tox	onsequence		tery of	sease			-	10 years
8	Examiner						es te		~~				1	704000
		e e	Sequentially list conditions, if any, leading to immediate	b.			consequence		0					1230
/	nsit	듣	if any, leading to immediate cause. Enter Underlying Cause Ulscass or injury	<_										
	al-tra	Examin	that initiated events resulting in death) Last	c.	Due to	o (or as a o	consequence	of):						
8760,	icate be executed physician and s the buriat-transit	dlcal		d										
687	ficate p phy s the	0		- 0.				-						
Вох	death certifics e attending pl ed for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23		utcome of			35.4			23d.	Date of deliv	very
	that the death ned by the atter detached for u	cla	in the past 12 months?		4 Pre	gnant at tin	☐ Fetal death ne of death]Ectopic pregnancy] Other <i>(specify)</i>				Month	Day Year
P.O.		ys	9 Unknown		9□ Unk	nown								
- 6	The law requires that the tte has been signed by th vage 2 should be detache	by PI	Part II. Other significant condit	ions cont	ributing to	death but	not resulting i	in the u	nderlying cause give	n in Part I.	23e. Did to	bacco use c	contribute to	the cause of death?
*	w requires to been signed should be	D D	lementia	< , l	Nypo	thy	roidi	sn			101	'es 2□N	o 3 ☐ Pro	bably 4 🗆 Inknown
Division of Vital Records	w requ	Completed		,	ί.	(24a. Was	an 24	b. Were aut	opsy findings available ompletion of cause of
Re	The lav	Ĕ										med?	death?	
a		e Co	25. Was case referred to medic	al						26. Place of Dea	- 107	2 ☑ No	1 🗆 Yes	213140
Ξ	Physician: this certific ral director,	o B	examiner?		ospital:	Inpatient	2 🗆 ER/O	utpatier	nt 3 DOA Othe		ome 5 Resid		Other (Spec	ifu)
of		—	27. Manner of Death	-	28a. Dat	e of Injury	28b.	Time o			28d. Describe h			.,,,
on	ding F th. After funer	ļ	1 Natural 5 Pend 2 Accident inves	ing tigation	(Mc	onth, Day Y	(ear)	Injury		(? /es 2 □ No				
İSI	Attending in death.	fica	3 ☐ Suicide 6 ☐ Could		28e. Pla	ce of Injury	/ - At home, fa	arm, sti	eet, factory, office				ımber or Rui	ral Route Number,
S	al or Attend after death I Director: A d in by the f	Certification:	4 Homicide		buil	lding, etc.	(Specify)				City or Tox	m, State)		
	spita nours norel		29a. Certifier 1 Certify	ing Phys	ician: To ti	he best of	my knowledg	e, deat	h occurred at the time	e, date and place	, and due to the	cause(s) and	manner as	stated.
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Check only 2 Medica one)	I Examin	er: On the and ma	basis of e anner state	xamination aid.	nd/or in	vestigation, in my op	oinion, death occur	rred at the time,	date and pla	ce, and due	to the cause(s)
	To the within To the comp	Σ	29b. Signature and title of certif	ier					29c. License	number		29d. Date sig	gned (Month	, Day, Year)
)	1					1	ww).	D	4110	1)	8 0	4
	M		30. Name and address of perso	n who cor	mpleted ca	use of dea	ith (Item 23a)	(Туре,	Print)			18	-3	
			Ted Ho	Ule	MD	78	125	Yo.	rk Kd	1000	son u	W	412	104
		ate	31. Date filed (Month, Day, Yea	r)	32.	Registrar'	s Signature		-0.7					
	Regist	rar	+8AL 1 2 2	nn/	None	1000	15 1	234	21					

ORIGINAL

•			For State Registrar	State of Maryland		ment of H		ental Hygier		00520
	Physici	an	Decedent's Name (First, Middle, Last)	Hunter	== ;			2. Date of Death Month	ay Year	3. Time of Death
	/Medic Examin	ai	HEZEKIAM 4a. Facility Name (If not institution, give s			b. City, Town, or	Location of Death	ANUMRY	tc. County of Death	14)2
	Examin	Ci	St. Agnes	tealthca		13017	more		NA	
1	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I		f Under 1 Year Ionths Days	Hours Min.	8. Date of Birth (Month, Day, Yea	ir) Coun	Nace (State or Foreign htry)
	Director		Usual Residence of Decedent	70			Ψ	019 12/17		
	r 28a-f show	'n	10a. State 10b. County		, Town or Locat				1	0d. Inside City Limits Your es 2 □ No
	1 the N	rect	10e. Street and Number		BAITH	10f. Zip Code		10g. 0	Citizen of What Cour	ntry?
	ath with 23a or ust be	Funeral Directo		HE16HTS 1	A16		215		USA	
	ltems	une	11. Marital Status	12. Was Decedent Ever in U.: Armed Forces?- 1 ☐ Yes 2 No	S. 13. Wa	s Decedent of Hilles, specify Cuba	spanic Origin? (Spec n, Mexican, Puerto F	ify Yes or No- ican, etc.)	14. Race - Americ Black, White,	
036	urs aft	by	1 Never Married 27 Married 3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1	Yes 25 No	Specify:		Specity: Blace	cla
21215-0036	within 72 hours after death with the Marylend ene. than "natural", or tems 23a or 28a-f show he Modical Exeminer mast be notified at	Completed	15. Decedent's Edu (Specify only highest grade	cation completed)	(Give kin	t's Usual Occupa d of work done d	luring most of workin		Kind of Business/Inc	dustry
121		ldwc	Elementary/Secondary (0-12)	College (1-4or 5+)	ite DO	NOT use retired,	1	aler Ru	John DE	CHIRO, Inc
		Be C	17. Father's Name (First, Middle, Last)		1101109	7-7"	18. Mother's Name	(First, Middle, Maide		
Vlar	should be nd Mental marked o	ToE	HEZEKIAH HU				Mary M		/	
Maryland	01 00 00		19a. Informant's Name/Relationship (Ty				and Number or Rural			
<u></u>	The E		20a. Method of Disposition	20b. P	lace of Disposition	on (Name of	Di	te 30c.	Location - City or To	wn, State
3altimore,	Pege ment o ant: If ury or		1 ☐ Surial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	ylow	Notional	Manuella	(Fach	LAURI	Manglas
Balt	permit. Peges Department of t Important: If its any injury or of		21. Signature of Funeral Service Linense	90	22. N	ame and Addres	s of Facility CAT	- REANS	HARRIU	own, State Man (No Fine roll lines
	*		23a. Party Enter the disease, or compli	cations that caused the death	n. Do not enter t	he mode of dying	Md 3/3 g, such as cardiac or	respiratory arrest,		Approximate Interval Between
	Physician		shock, or heart/ailure. List only or Immediate Cause (Final disease or condition	A SPIRA	710N	PNEU	พออเล		-	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ		1 /-				
4		er		o. — Due to (or as a consequ	zence of).					
1	and I-transit	Examiner	any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
\\S	be ey cian cian		resulting in death) Last	Due to (or as a consequ	uence of);					
687		edical								
Box 6	attending for use a	M/UE	230. was decedent pregnant	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		topic pregnancy			23d. Date of delive	
B	it the deatl by the atter tached for	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of de 9☐Unknown		ther (specify)			Month	Day Year
± 0.0	2 5 9	/ Ph	Part II. Other significant conditions cor		ulting in the unde	erlying cause give	en in Part I.	23e. Did tobacco	o use contribute to th	ne cause of death?
月62日と144 Vital Records, F	w requires been sign should be	ed by	DEHYDRA					1 ☐ Yes	2 □ No 3 □ Prob	ably 4 Dunknown
Z (S)	e law re has bee je 2 sho	Completed	URINARY	Treact	INFEC	TION		24a. Was an autopsy	prior to cor	psy findings available mpletion of cause of
7. E	: The cete hat page							performed?		2 No
	OF 17. 1	o Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \)	lospital: 1 X Inpatient 2 🗍	ER/Outpatient	3□ DOA Othe	26. Place of Death		6 ☐Other (Specify	arl
of to	ding Phys h. After this funeral di	h- 1	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		8d. Describe how in		7
Sior Sior	uttendin death. ctor: Af y the fur	catlc	2 Accident survestigation 3 Suicide 6 Could not be			M 1 🗆 Y	Yes 2□No	M. I		75
UNTER Division	l or At after d Direct I in by	Certification:	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street	, factory, office	2	City or Town, Sta	and Number or Rura ate)	I Houte Number,
7	To the Hospital or Attendi within 24 hours after death. To the Eunerel Director: A completely filled in by the fu	calc		sician: To the best of my kno- ner: On the basis of examinat						
	ths H hin 24 the Fi	Medical	one)	and manner stated.		29c. License			Date signed (Month,	
	5 Mills To		29b. Signature and title of bertifier	h						
7	X		30. Name and address of person who co	ompleted cause of death (Item	23a) (Type, Pri	nt)			,)	4 2004
	U		EBENEZER QU		44 NE	s HEX	AUTH CA	NE BA	LTIMOR	2.0
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	,				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 3:20 PM TARMON AMES JAX 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) SEP HOSPICE RICHEY 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 9 215-42-Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b County or 28a-f show the Medical Examiner must be notified at 1 Nes 2 No Director MARYLAND 10g. Citizen of What Country? 10e. Street and Number 21216 ALVERTON HEIGHTS Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🗷 No Baltimore, Maryland 21215-0036 "natural", or Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any injury or other traumatic event, the Medic 2006. Elementary/Secondary (0-12) College (1-4or 5+) UNITED STEELWORKERS ATOR 12 +HGRADE 18. Mother's Name (First, Middle, Maiden Sumame) (UN KNO IUN) 17. Father's Name (First, Middle, Last) Be TAMES MALEANA 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) (DAUGHTER) RIVE, EDGEWOOD MD. IENAA Date 20c. Location City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State CREMATORY 01-16-04 BALTIMORE, MARYLAND * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility BROWN JR. FUNE, 598 N. FULTON AVE, BALTO. . FUNERAL HOME 21. Signature of Funeral Service License MD, 21211 Þ 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory afrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MOS ilizean /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.O. detached 9 Unknown 9 DUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 3 ☐ Probably 4 Zunknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page 2 1 Yes funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1. Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funerel Director: completely filled in by the 6 ☐ Could not be 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Swilli Benedict D008583 1/11/2004 his 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BACKMONZ, G.W. WIAM BENEDICI, M.D. 6565 NCharles St. 31. Date filed (Month, Day, Year) JAN 1 3 2004 32. Registrar's Signature State Registrar

かつら

TARION

FARR

	1	V State Amend & Unperent V Registrar Decedent's Name (First, Middle, L								. Date of Dea	ath	40 100	3. Time of Death	4
sician		Mark E. Heilman,	V						-	Month January	Day	Year 104	415 a	М
edical miner	4:	a. Facility Name (If not institution, gi				4b. City	, Town, or	Location of De		amucin)		unty of Deal		
		1802 Rambling R	ldge Way	apt. 2	:01	Gr	eensp	ring				Balt	imore	
ral	5.	Social Security Number 6.	Sex 1 M 2 □ F	7. Age (<i>I</i> n <i>yr</i> s.		ff Unde	or 1 Year Days	If Under 24 H Hours Mi	rs. 8 n.	. Date of Birt (Month, Day	h y, Year)	9. Birt	hplace (State or Forei	gn
or	L	216-76-8206	TUS M ZUF		35 Yrs.					Nov 27				
65	-	sual Residence of Decedent 0a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limit	s
by Funeral Director													1 □ Yes 2 ☑1	1
Director	1	MD Baltim Oe. Street and Number	ore	Ва	ltimor	_	ip Code				10a Citizen	of What Co	nuntry?	
ā			das Tono	7	201		209						•	
Funerai	1	1802 Rambling Ri 1. Marital Status	12. Was Dece	dent Ever in U				spanic Origin? n, Mexican, Pu	(Speci	fy Yes or No-		ed Sta Race - Ame	nican Indian,	
큔		1 Never Married 2 Married	Armed For 1 ☐ Yes	2 🖫 No					erto Ri	can, etc.)		Black, White	e, etc.	
þ	١.	3 ☐ Widowed 4 ☐ Divorced	ff Yes, Give Year or Da	tes:		1 🗌 Yes	2 M No	Specify:			Sp	ecify: Whi	to	
Completed		15. Decedent's E (Specify only highest g			16a. Dece	dent's Usi	ual Occupa	ation during most of w	ndrina		16b. Kind	of Business/		
npie		Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT	use retired)	og		Healt	h Car	е	
S	_		5+		Clair	ns Au	dito							
Be	1	7. Father's Name (First, Middle, Las	•					18. Mother's N	ame (i	First, Middle,	Maiden Sui	mame)		
To Be Completed		Mark Edwin John		, IV	_			Sheila						
To		9a. Informant's Name/Relationship			19b. Mailir	ng Addres	is (Street a	and Number or	Pural P	Route Numbe	r, City or To	wn, State, 2	Zip Code)	
	_	Mr. Greg Blackwo	ood/Partr		1802 Place of Dispo	Ramb	oling	Ridge_	Lan				imore, MD	_
	12	0a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 [☐Removal from S		cemetery, crer	natory or	other place	θ)	_	n 10	20c. Locati	on - City or	Iown, State	
oj.		`4 □ Donation 5 □ Other (Spec		C	nesapea					004	Belts	ville	, MD	
once.	2	1. Signature of Funeral Service Lice	ensee	MOO				s of Facility and Fi	ner	al 51+	cenat	inos		
ŭ.		NW	w			8717	Gree	n Pasti	res	Drive	Pal	timor	e, MD	
79(h		23a Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that ca one cause on ea	lused the deat ich fine.	h. Do not ent	er the mo	de of dying	g, such as cardi	ac or r	espiratory ar	rest,		Approximate fnterval Between Onset and Death	
an	0	mmediate Cause (Finaf disease or condition esulting in death)	a. CARD	EAC ARE	IMHTYH	Λ							Criset and Death	
al er	,	esularing in dealtry	Due to (or as a conseq	juence of):									
1	GJ W	sequentially list conditions, any, leading to infried at ause. Enter Underlying	b. Due to 6	r as a conseq	mention off-									
i i	c	ause (Disease or injury			31).							- 1		
Examiner	r	nat initiated events esulting in death) Last	c. Due to (d	or as a conseq	uence of):									-
cal			. d									- 1		
			u											
Physician/Med	11	F FEMALE: 3b. Was decedent pregnant	23c. If yes, outo								23d.	Date of deli	verv	
Cial		in the past 12 months?	4☐ Pregna	nth 2 ☐ Feta ant at time of d		JEctopic p Other (s	pecify)					Month	Day Year	
hys	1	9 Unknown	9□ Unkno	wn										
		art II. Other significant conditions	contributing to de	ath but not res	utting in the u	nderlying	cause give	in in Part I.		23e. Did to	bacco use o	contribute to	the cause of death?	
- 2	_	HIV INFECTION							.	1 □ Y	es 2□N	o 3 □ Pro	obably 4 🛍 Unknow	n
0	1									24a, Was a	an 24	tb. Were au	topsy findings availab	e
ojetec	-									autop:	med?	prior to death?	completion of cause of	
ompietec		5. Was case referred to medical						26. Place of D	nath (f	1 X Yes		1 X Yes	2 No	
e Completed by		examiner? 1X Yes 2 No	Hospital:	patient 2	ER/Outpatien	t 3 D	Cthe			5 🗆 Resid		Other (Con	at sce	ne
Be	2	The second second	28a. Date o		28b. Time of		28c. Injury Work			d. Describe h			illy) at sec	110
To Be	2	7. Manner of Death		n, Day Year)	Infury	М		? /es 2 ☐ No						
To Be	2	1 XNatural 5 ☐ Pending	/11	of Imirone At In-	ome, farm, str	eet, factor	y, office		28f	Location (S	treet and No	umber or Ru	ral Route Number,	
cation; To Be	2	1 XNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not	28e. Place	or injury - Acric	v)					City or Tow	n, State)			
cation; To Be	2	1 XNatural 5 ☐ Pending investigation	28e. Place	g, etc. (Specif	,									
cation; To Be	2	1 XNatural 2 Accident 3 Suicide 4 Homicide 1 Certifier 1 Certifying P	28e. Place buildin	g, etc. (Specification)	wledge, death	occurred	at the tim	e, date and pla	e, and	due to the c	ause(s) and	manner as	stated.	
cation; To Be	2	1 XNatural 2 Accident 3 Suicide 4 Homicide 1 Certifier 1 Certifying P	28e. Place	g, etc. (Specification) best of my knows is of examina	wledge, death	occurred estigation	at the tim	e, date and plai inion, death oc	e, and	due to the cat the time, d	cause(s) and date and pla	manner as ce, and due	to the cause(s)	
To Be	2	1 Natural 2 Accident 3 Suicide 4 Homicide 10 Certifier (Check only one) 11 Certifying P 2 Medical Exis	28e. Place buildin	g, etc. (Specification) best of my knows is of examina	wledge, death	vestigation	n, in my op	inion, death oc	e, and	at the time, d	date and pla-	ce, and due	to the cause(s)	
Certification: To Be	2	1 Natural 2 Accident 3 Suicide 4 Homicide 10 Certifier (Check only one) 11 Certifying P 2 Medical Exis	28e. Place buildin	g, etc. (Specification) best of my knows is of examina	wledge, death	vestigation	n, in my op	inion, death oc	e, and	at the time, d	date and pla-	ce, and due	to the cause(s)	
cation; To Be	2	1 Natural 2 Accident 3 Suicide 4 Homicide 10 Certifier (check only one) 10 Certifier (check only one) 11 Certifying P 2 Medical Exit	28e. Place buildin	g, etc. (Specification) best of my known of examination of examina	owledge, death	vestigation 29	n, in my op	inion, death oc	e, and	at the time, d	date and pla-	ce, and due	to the cause(s)	
cation; To Be	2	1 Natural 2 Accident 3 Suicide 4 Homicide 10 Certifier (Check only one) 11 Certifying P 2 Medical Exis	28e. Place buildin hysician: To the miner: On the ba and mann M. D.	g, etc. (Specification) best of my known of examination of examina	owledge, death	29 (Print)	n, in my op ic. License	inion, death oc	curred	at the time, d	date and pla 29d. Date sig Janua	gned (Month	to the cause(s)	

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 01 - 09 -**Physician** 1120 MILDRED 2004 HANDY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** MERCY MEDICAL CENTER BALTIMORE MO 21201 8. Date of Birth (Month, Day, Year) May 25, 1912 Birthplace (State or Foreign Country)

Md. If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 X F 217-03-2187 91 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County event, the Medical Examiner must be notified at Baltimore 1 AYes 2 No N/A Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21213 1712 E. Lafayette Ave. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Black 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) US. Customs House Elementary/Secondary (0-12) College (1-4or 5+) House Keeping 12 permit. Pages 1 and 2 should be filed Department of Health and Mental Hygin Important: if item 27 is marked other any injury or other traumatic event, Il 18. Mother's Name (First, Middle, Maiden Sumame)
Augusta Barnes 17. Father's Name (First, Middle, Last) Arthur Barnes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 923 Belnord Ave. Baltimore, Maryland 21205 Theresa Fagan 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 01/12/04 Catonsville, Maryland Metro Crematory 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Estep Brothers Funeral Home P.A.
1300 Eutaw Place Baltimore, MD 21217 21. Signature of Funeral Service Licensee 11. Enter the disease, or conflications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) URINARY TRACT INFECTION Physician /Medical Due to (or as a consequence of): Examiner BACTEREMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 DEctopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed NECROTIC HIP ULCER 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 1 Yes 2 No HNEMIH funeral director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Diractor: A 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier P17655 ger-lutur, MD 01-09-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

eslie P.

31. Date filed (Month, Day, Yan)

Baltimore, Maryland 21215-0036

of Vital Records,

Division

Pay Street Baltimore, MD 21201

Osei-Tutu · 301 ST.

32 Registrar Signature

A Marie

	-	For State		, , , , , , , , , , , , , , , , , , , ,		rtificate of	lealth a Death			Reg. No.	200		
		Registrar 1. Decedent's Name (First, Midd	dle, Last)						2. Date of De	ath		3. Time of Dea	
Physicia /Medic		Charles Alb	ert Hamil	ton, Sr					Januar	_{Д 10}		5:10	
Examin	4.	4a. Facility Name (If not instituti	ion, give street and nu			4b. City, Town, o	or Location o	of Death		4c.	County of De		
A.		Stella Maris 5. Social Security Number	Hospice 6. Sex	7. Age (In yrs.	last hirthdayl	Timon:		24 Hrs.	8. Date of Bir	rth	Baltir		
Funeral Director		216-12-8895	3 X M 2 □ F	80	Yrs.	Months Days		Min.	(Month, Di Jnue 9	ay, Year)		irthplace (State or For Country) aryland	
ehow dd at	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location										10d. Inside City Li	
28a-f	ecto	Maryland 10e. Street and Number		B	altimo	10f. Zip Code				10g. Citiz	zen of What C	Country?	
3a or		3705 Ina Ave	nue			1	206					SA	
me 2	Funeral Director	11. Maritat Status	12. Was Dec	cedent Ever in U.	.S. 13.	Was Decedent of I	Hispanic Ori	igin? (Spe	ecity Yes or No	o- '		nerican Indian,	
, or ite	by Fu	1 Never Married 2 Ma 3 XWidowed 4 Divorce	arried 1 XYes	2 No		1 ☐ Yes 2 XNo			, , , , , , ,		Black, White, etc. Specify:		
Stural Ed Es		15. Decede	ent's Education		16a. Dece	dent's Usual Occu	pation			16b. Kir	nd of Busines	White ss/Industry	
f Health and Mental Hygiene. Item 27 le marked other then "natural", or Iteme 23a or 28a-1 ehov other traumatic event. Ite Medical Examinet mart be notified at	Completed	(Specify only high Elementary/Secondary (0-12)	nest grade completed College	(1-4or 5+)	(Give life. Manaq	kind of work done DO NOT use retire	during mos id)	t of worki	ng	Reta	Retail Electronics		
other other	Be C	17. Father's Name (First, Middle	e, Last)		- Lacing	Ÿ .	18. Mothe	er's Name	(First, Middle				
Menta arked atic e	To E	Albert Fost	er Hamilt	on					. Virg				
le ma		19a. Informant's Name/Relation		- / Con		ng Address (Street							
of Health item 27 I r other tre		Charles A. Ha	IIII CON, JE			M Tall I	Pines		Abing			and 21009 or Town, State	
Department of the Important: If its end injury or of once.		1 ₩ Burial 2 Cremation		n State	cemetery, cre	matory or other pla	1						
artme ortani injury		* 4 ☐ Donation 5 ☐ Other 21. Signature of Feneral/Service		Du.		Valley Me 2 Name and Addr McComas 1					onium,	Maryland	
Impo eny ir		1 Staller	12 March			McComas I	unera	at Ho	me.P.	Α.			
ysician Medical		23a. Pert1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)	ist only one cause on	each line.	th. Do not en	1317 Coke	esbury	7 Roa	d, Abi	ngdor	n, MD 2	Approximate Interval Between Onset and Deat	
Medical caminer	cal Examiner	shock, or heart failure. Li Immediate Cause (Final disease or condition	a. CEI Due to b. Other to	each line. REBROVAS	CULAR quence of):	1317 Coke	esbury	7 Roa	d, Abi	ngdor	n, MD 2	Approximate Interval Between	
attending physicien and lor use as the burial-transit	E I	shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, feeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. CEI Due to b. Cive to d. 23c. If yes, o	each line. REBROVAS o (or as a consequence) o (or as a consequence) utcome of pregnal birth 2 Feta	CULAR (uence of):	1317 Coke	esbury	7 Roa	d, Abi	ngdor arrest,	23d. Date of d	Approximate Interval Between Onset and Deat	
signed by the attending physicien and inpiped to use as the burial-transit or be detached for use as the burial-transit.	by Physician/Medical Ex	shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 yes 2 No	a. CEI Due to b. Oue to c. Due to d. 23c. If yes, o 1 Live 4 Pred 9 Unk	each line. REBROVAS o (or as a consequence of or as a consequence of pregnation of pregnation at time of consequence of or as a consequence of pregnation of or as a consequence or as a consequence of or as a consequence or a consequence or a consequence of or as a consequence or a	CULAR (uence of): quence of): quence of): ancy al death 35	1317 Coke ter the mode of dyi ACCIDENT BECtopic pregnanc Other (specify)	esbury	7 ROa	d, Abi	ngdor arrest,	23d. Date of d Month	Approximate Interval Between Onset and Deat	
e has been signed by the attending physicien and inpipals and inpipals as the burial-transit or or	by Physician/Medical Ex	shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, feeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	a. CEI Due to b. Oue to c. Due to d. 23c. If yes, o 1 Live 4 Pred 9 Unk	each line. REBROVAS o (or as a consequence of or as a consequence of pregnation of pregnation at time of consequence of or as a consequence of pregnation of or as a consequence or as a consequence of or as a consequence or a consequence or a consequence of or as a consequence or a	CULAR (uence of): quence of): quence of): ancy al death 35	1317 Coke ter the mode of dyi ACCIDENT BECtopic pregnanc Other (specify)	esbury	7 ROa	23e. Did	tobacco u Yes 2[s an psy	23d. Date of d Month use contribute □ No 3 □ I	Approximate Interval Between Onset and Deat Deat Deat Deat Deat Deat Deat Deat	
rificate has been signed by the attending physicien and inport, page 2 should be detached for use as the burial-transit of or	Physician/Medical Ex	shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, feeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	a. CEI Due to b. Check c. Due to d. 23c. If yes, o 1 Live 4 Prey 9 Unk iitions contributing to	each line. REBROVAS o (or as a consequence of or as a consequence of pregnation of pregnation at time of consequence of or as a consequence of pregnation of or as a consequence or as a consequence of or as a consequence or a consequence or a consequence of or as a consequence or a	CULAR (uence of): quence of): quence of): ancy al death 35	1317 Coke ter the mode of dyl ACCIDENT □Ectopic pregnanc □ Other (specify) □	ey ven in Part	ROA cardiac c	23e. Did 1 24a. Wa. auto 1 Yes	tobacco u Yes 2[s an posy ormed? 2X No one)	23d. Date of d Month see contribute No 3 1 24b. Were prior to death 1 Ye	Approximate Interval Between Onset and Deat Onset and Deat Deat Deat Deat Deat Deat Deat Deat	
is certificate has been signed by the attending physicien and input director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical Ex	shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significent condesseminer? 25b. Was case referred to mediexaminer?	a. CEJ Due to b. Cue to c. Due to d. 23c. If yes, o 1 Live 4 Pre- 9 Unk litions contributing to	each line. REBROVAS o (or as a consequence of or as a consequence of pregnant at time of consequence of or as a consequence of pregnant at time of consequence of or as a consequence of pregnant at time of consequence of or as a consequence of pregnant at time of consequence of pregnant at time	CULAR (uence of): quence of): ancy al death 5 [sulting in the uence of the content of the con	1317 Coke ter the mode of dyi ACCIDENT Bectopic pregnand Other (specify) underlying cause gi	ey ven in Part	Roac cardiac c	23e. Did 1 24a. Was autopert 1 Yes 1 (Check only me 5 🗆 Res	tobacco u Yes 2[s an psy ormed? 2X No one) idence 6	23d. Date of d Month use contribute No 3 i 24b. Were prior to death' 1 You	Approximate Interval Between Onset and Deat Onset and Deat Deat Deat Deat Deat Deat Deat Deat	
After this certificate has been signed by the attending physicien and Dipply funeral director, page 2 should be detached for use as the burial-transit of Dipply funeral director, page 2 should be detached for use as the burial-transit of Dipply funeral directors and Dipply funeral directors are provided by the state of the state of the provided by the state of the provided by the state of the provided by the state of the state of the provided by the state of the sta	To Be Completed by Physician/Medical Ex	shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. CEI Due to b. Check c. Due to d. 23c. If yes, o 1 Live 4 Pre- 9 Unk itions contributing to iding stigation 28a. Dat (Mo	each line. REBROVAS D (or as a consequence of or as a consequence of pregnant at time of or nown death but not result of the consequence of the	CULAR (uence of): quence of): quence of): ancy al death 3 [death 5 [dea	1317 Coke ter the mode of dyi ACCIDENT □Ectopic pregnanc □ Other (specify) □ underlying cause gi ant 3□ DOA Other 28c. Inju W M 1□	26. Place ther: 4X Noting at tark?	Roac cardiac c	23e. Did 1 1 24a. Wa. autoper 1 1 Yes 1 (Check only me 5 Res. 28d. Describe	tobacco u Yes 2[s an posy ormed? 2X No one) idence (how injur	23d. Date of d Month Ise contribute No 3 1 24b. Were a prior to death 1 1 Ye 6 1 Other (Sp. y occurred	Approximate Interval Between Onset and Deat Onset Onse	
After this certificate has been signed by the attending physicien and Dipply funeral director, page 2 should be detached for use as the burial-transit of Dipply funeral director, page 2 should be detached for use as the burial-transit of Dipply funeral directors and Dipply funeral directors are provided by the state of the state of the provided by the state of the provided by the state of the provided by the state of the state of the provided by the state of the sta	To Be Completed by Physician/Medical Ex	shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. CEJ Due to b. Cue to c. Due to d. 23c. If yes, o 1 Live 4 Pres 9 Unk itions contributing to iding istigation lid not be 28e. Pla.	each line. REBROVAS D (or as a consequence of or as a consequence of pregnant at time of or nown death but not result of the consequence of the	CULAR [uence of): [uence of]: 1317 Coke ter the mode of dyi ACCIDENT Ectopic pregnanc Other (specify) underlying cause gi	26. Place ther: 4X Noting at tark?	Roac cardiac c	23e. Did 1 24a. Was autopert 1 Yes 1 (Check only me 5 Res 28d. Describe	tobacco u Yes 2[s an posy ormed? 2X No one) idence (how injur	23d. Date of d Month Ise contribute No 3 1 24b. Were prior to death 1 Ye 6 Other (Sp y occurred	Approximate Interval Between Onset and Deat Onset and Deat Deat Deat Deat Deat Deat Deat Deat		
Figure after death. Funeral Director: After this certificate has been signed by the attending physicien and in property filed in by the funeral director, page 2 should be detached for use as the burial-transit of property filed in by the funeral director, page 2 should be detached for use as the burial-transit of property filed in by the funeral director.	Certification: To Be Completed by Physician/Medical E)	shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. CEI Due to b. Cue to c. Due to d. 23c. If yes, o 1 Live 4 Prey 9 Unk itions contributing to iding stigation aid not be armined 28e. Pla buil tying Physician: To the call Examiner: On the	each line. REBROVAS Deforme of pregnation	CULAR (uence of): quence of): quence of): ancy al death 5 [sulting in the uence of the content of the conte	Table 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ven in Part 26. Place ther: 4 No. ary at ork? Yes 2	Roac cardiac c	23e. Did 1 24a. Was auto performed to the City or To and due to the and due to th	tobacco u Yes 2[s an ppsy ormed? 200 No one) idence (how injur (Street an wwn, State)	23d. Date of d Month Ise contribute No 3 I 24b. Were a prior to death 1 Yes 6 Other (Sp y occurred	Approximate Interval Between Onset and Deat Onset Onset and Deat Onset O	
if the death. Director: After this certificate has been signed by the attending physicien and Director. After this certificate been signed by the attending physicien and Director. Page 2 should be detached for use as the burial-transit C Director.	To Be Completed by Physician/Medical Ex	shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leculing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. CEI Due to b. Check c. Due to d. 23c. If yes, o 1 Live 4 Pre- 9 Unk itions contributing to iding stigation iding stig	each line. REBROVAS D (or as a consequence of or as a consequence of pregnant at time of consequence of the consequence of th	CULAR (uence of): quence of): quence of): ancy al death 5 [sulting in the uence of the content of the conte	1317 Coke ter the mode of dyi ACCIDENT Coke C	ven in Part 26. Place ther: 4 No. ary at ork? Yes 2	Roac cardiac c	23e. Did 1 24a. Was auto performed to the City or To and due to the and due to th	tobacco u Yes 2[s an ppsy ormed? 200) idence (how injur (Street an wwn, State) cause(s) , date and	23d. Date of d Month Ise contribute No 3 1 24b. Were a prior to death 1 Ye 6 Other (Sp y occurred d Number or i) and manner of place, and di	Approximate Interval Between Onset and Deat Onset Onset and Deat Onset O	
Figure after death. Funeral Director: After this certificate has been signed by the attending physicien and in property filed in by the funeral director, page 2 should be detached for use as the burial-transit of property filed in by the funeral director, page 2 should be detached for use as the burial-transit of property filed in by the funeral director.	Certification: To Be Completed by Physician/Medical E)	shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significent cond 25. Was case referred to mediexaminer? 1 Yes 2 No 27. Manner of Death to Natural sinve accident inve accident sinve accident	a. CEI Due to b. Check c. Due to d. 23c. If yes, or 1 Live 4 Pre- 9 Unk itions contributing to iding stigation ald not be armined 28a. Pla buil tying Physician: To the and ma ifter	each line. REBROVAS Do (or as a consequence of or as a consequence of pregnation and the consequence of th	CULAR (uence of): quence of): quence of): quence of): quence of): quence of): quence of): quen	accident the mode of dying the mode of the mode	26. Place ther: 4X No lime, date an opinion, decise number	Roac cardiac control of the cardiac control o	23e. Did 1 24a. Was auto performed to the City or To and due to the and due to th	tobacco u Yes 2[s an ppsy ormed? 280 no idence (Street an wan, State c cause(s) , date and	23d. Date of d Month Ise contribute No 3 1 24b. Were a prior to death 1 Ye 6 Other (Sp y occurred d Number or i) and manner of place, and di	Approximate Interval Between Onset and Deat Onset Onset and Deat Onset Onse	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death	Reg. No. 200	4 00525
Physician	1. Decedent's Name (First, Middle, Last)	2. Date of Deeth Month Dey Ye	3. Time of Death
/Medical	Dewitt Scott Hoover	Jan 07 200	04 7.43 am
Examiner	4a Facility Name (If not institution, give street and number) Mariner Health of Bel Air Bel Air		
	5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Year)	
Funeral Director	Months Days Hours Min.	Jun. 23, 1927 V	Birthplece (State or Foreign Country) 7irqinia
D .	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
ith the Marylar or 28s-f show or mothlise at	Maryland Harford Joppa		1 ☐ Yes 2½ No
r 28a-	10e. Street and Number 10f. Zip Code	10g. Citizen of Wha	t Country?
Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mantal Hydrath in Tratural; or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	300 Magnolia Road 21085	USA	
tems tems	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto I	ricify Yes or No- Rican, etc.) 14. Race - A Black, V	American Indian, Vhite, etc.
ns after r., or I	1 Never Married 2 Married 1 ⊠ Yes 2 No II Yes S Give 1 Yes 2 ☑ No Specify: 3 □ Widowed 4 ☑ Divorced Year or Dates: ₩III	Specify:	White
2-00 2 hours sture		16b. Kind of Busine	ess/Industry
1 21215-0020 led within 72 hours a vigene. Per than "natural", on it, the Medical Event Completed by	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)	/ - <u>1</u>	
led w lygien H, the th	12 Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name	Independe	ent
and and a be filed and the filed other sevent, I be Co		(First, Middle, Maiden Sumame) • (Unknown)	
aryla should nd Men nerke merte merte	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura		te, Zip Code)
y, Maand 2 is and 2 is a nath a in 27 is en trau	Joy Cornell-Baker/Daughter 9352 Birchwood Court, 1	· · · · · · · · · · · · · · · · · · ·	
Ore, set 1 a of Hear I term	20a. Method of Disposition 11 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Neme of cemetery, crematory or other place)	Date 20c. Location - City	or Town, State
lime Pagement ment ant: II		-10-04 Fallston	, MD
Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filled within 72 hours aft Department of Health and Mental Hygiene. Important; if Item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examples. To Be Completed by F	21. Signature of Euneral Service Licensee 22. Name and Address of Facility McComas Funeral Home	e, P.A.	
- 40=66	Tuste (1 / Neigh 1317 Cokesbury Road	, Abingdon, MD 2	
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o shock, or heart failure. List only one cause on each line.	r respiratory arrest,	Approximate Interval Between Onset and Death
Physician /Medical	Immediate Cause (Final		3 0/001
	disease or condition resulting in death) a. The union 1 a. Due to (or as a consequence of):		Says
>	Due to (or as a consequence of).		
Vision of Vital Records, P.O. Box 68760, Athendrap Physician: The law requires that the death certificate be executed redeth. Sector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the bunal-transit principle.	Sequentially list conditions.		+
60, be ex be ex burial.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury C		
68760, ifficate be exerging physician as the burial-ledical Ex	that initiated events Due to (or as a consequence of): resulting in death) Last		
Box (auth certif attanding for usa a	d		
O. Box edath cert the attanding thed for usa	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contrib	oute to the cause of death?
The law requires that the death central has been signed by the attending page 2 should be detached for use completed by Physician/N		1 Yes 2 No 3□	Probably 4 Unknown
cords, P		24-14	4b. Were autopsy findings
Core requirements		24a. Was an autopsy 24 performed?	available prior to completion of cause
Records, he law requiras the has been signe aga 2 should be c		1⊒Yes 2XNu	of death?
of Vital Re Physician: The I this certificate harral director, page : To Be Com	25. Was case referred to medical 26. Place of Death		1 Yes 2 No
Of Vi Physicia this cer ral direct	examiner?	ne 5 Residence 6 □Other (S	Specify)
in of in of ang Physical districtions and Toon: Toon: Toons on: Toons on the angle of the angle	1 Matural 5 Pending (Month, Day Year) injury Work?	28d. Describe how injury occurred	
isio isio isio isio death. tor: A the fu	2 Accident investigation M 1 Yes 2 No	28f. Location (Street and Number of	s Pural Pouta Mumbar
Division of Attending after death. Director: After din by the fune din by the function din by the func	4 ☐ Homicide determined City or Town, State)	r nural noute Nulliber,	
Division o To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After it completely filled in by the funera	29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, a	nd due to the cause(s) and manne	r es stated.
the Ho in 24 the Fu pletel	(Check only one) Z Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.		
To the within 2 To the comple	29b. Signature and title of certifier 29c. License number	29d. Date signed (M	lonth, Day, Year)
- KU	N M MD 1 D3465 2	Vanuary	1,2004
1)	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Many Jund	2)17)4
State	31. Date filed (Month, Day, Year) 32. Registres Signature	1777	,,,,
Registrar	JAN 1 3 2004 Meser & April		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar AMEND ITEM #1 PER PHY G827 1/13/0 Continuous of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death CTIC LOVIE M. HOLLEY-GILL Month Day Year Physician JANUARY OR 10: 15 AM Q00 H /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SAMARITAN HOSPITAL BALT IMORE 400D 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 201F Months Days Hours 218-88-0632 Director October 3, 971 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examples or near the indiffer at 1 Yes 2 No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 561 USA Road 21206 Itrecht Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married 5-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry laryland 2121 ges 1 and 2 should be filed within it of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Waitress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wendell Bear Darlene Holley Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Road ≥ Varlene Beard 5615 Baltmone MD 21206 mother Utrecht Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Methodrof Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ö Department of Important: If any Injury or once. 7/04 4 □ Donation 5 □ Other (Specify) Mt. Carmal Cem Baltimore MD 21. Signature of Funeral Service Licensee 22. Name, and Address of Facility Havi P. Close Funeral Sewice, P. A. 709 Tessier St. Baltimore MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ADULT RESPIRATORY DISTRESS SYNDROME /Medical **Examiner** PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) certificate be executed physicien and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medicai attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) o the th detached δ been signed be should be deta Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ HODGKIN'S LYMPHOMA 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 certificate Vital 2 □ No director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA ð this After this funeral of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Division or Attending Fatter death. 1-Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the within 24 hours after deatl To the Funeral Director; 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Hospital Medicai 29a. Certifier ↑ Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature end title of certifier 29d. Date signed (Month, Day, Year) Bailonds M.D. RES-000 4005 CO ENAUNAL add s of person who completed cause of death (Item 23a) (Type, Print)

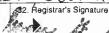
State Registrar

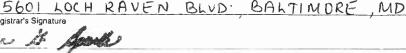
JAN 0 9 2004

GAITONDE

 \mathfrak{D}

31. Date filed (Month, Day, Year)





HOL

Was Decedent Ever in U. Armed Forces? 1	Iss. birthday) Yrs. If M Mrs. If Mrs. If Mrs. If Mrs. If Mrs. If M Mrs. If Mrs.	10f. Zip Code 21032 s Decedent of Hies, specify Cubai lyes 210 No It's Usual Occupa d of work done of NOT use retired, Operato	If Under 24 Hr. Hours Min Ispanic Origin? (n, Mexican, Pue Specify: ation furing most of win 18. Mother's Na Gertrud and Number or F	8. Date of Bird Month, Da Jan . I d	Anne Anne Year 191 10g. Citizen United Spe 16b. Kind o	of What Cour State Race - Americ Black, White, orify: Whi Business/In-	nace (State on nary) Od. Inside Ci 1 □ Yes http: S can Indian, etc. te dustry	P M r Foreign D.C.
et and number) al th & Rehab 7. Age (In yrs. 87) 10c. Cit al Crow Was Decedent Ever in U. Armed Forces? 1	Iss. birthday) Yrs. If M Mrs. If Mrs. If Mrs. If Mrs. If Mrs. If M Mrs. If Mrs.	ion 10f. Zip Code 21032 s Decedent of Hiese, specify Cubar 210 Work done of NOT use retired, Operato Address (Street a	If Under 24 Hr. Hours Min Ispanic Origin? (n, Mexican, Pue Specify: ation furing most of win 18. Mother's Na Gertrud and Number or F	Specify Yes or Norto Rican, etc.) Specify Yes or Norto Rican, etc.) Specify Yes or Norto Rican, etc.)	Anne Anne Year 191 10g. Citizen United 14. E Spe 16b. Kind o	Arund 9. Birthpe 6Washi of What Cour State Race - Americ Black, White, orify: Whi f Business/In-	el place (State on ng to n 10d. Inside Ci 1 Yes http? 5 can Indian, etc. te dustry	r Foreign D.C.
Alth & Rehab 7. Age (In yrs. 87 10c. Cit 1 Crow Was Decedent Ever in U. Amed Forces? 1 Jyes 2 M No lityes, Give Year or Dates: On Dampleted) College (1-4or 5+)	Iss. birthday) Yrs. If M Mrs. If Mrs. If Mrs. If Mrs. If Mrs. If M Mrs. If Mrs.	ion 10f. Zip Code 21032 s Decedent of Hiese, specify Cubar 210 Work done of NOT use retired, Operato Address (Street a	If Under 24 Hr. Hours Min Ispanic Origin? (n, Mexican, Pue Specify: ation furing most of win 18. Mother's Na Gertrud and Number or F	Specify Yes or Norto Rican, etc.) Specify Yes or Norto Rican, etc.) Specify Yes or Norto Rican, etc.)	Anne by Year 191 10g. Citizen United 14. F Spe 16b. Kind o Steel Maiden Sum	Arund 9. Birthp 6Washi of Washi of What Cour State Race - Americ Black, White, white, the Business/Inc. Manufa	nace (State on nary) Od. Inside Ci 1 □ Yes http: S can Indian, etc. te dustry	D.C.
2 □ F 87 10c. Cit 10c. Cit 10c. Cit 10c. Cit 21 Crow Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 ⋈ No If Yes, Give Year or Dates: If Yes, Give Year or Dates: On Ompleted) College (1-4or 5+)	Institution of Location of Loc	ion 10f. Zip Code 21032 s Decedent of Hi as, specify Cubai as, specify Cubai as, specify Cubai as Specify	ispanic Origin? (n, Mexican, Pue Specify: ation furing most of we 18. Mother's Na Gertrud and Number or F	Specify Yes or Norto Rican, etc.) orking me (First, Middle.	Year) 91 10g. Citizen United Spe 16b. Kind o Steel Maiden Sum	9. Birthp Cowashi of Washi of What Cour State Bace - Americ Black, White, or Business/In-	nace (State on nary) Od. Inside Ci 1 □ Yes http: Scan Indian, etc. te	D.C.
Was Decedent Ever in U. Armed Forces? 1	yrs. ty, Town or Location msville 2 2. 3. Was If Ye 1 16a. Decedent (Give kint life. DO) Machine 19b. Mailing A 381 Blc Place of Disposition commetery, cremate 1 1 crest M.	ion 10f. Zip Code 2 1 0 3 2 s Decedent of Hiss, specify Cubar 2 1	ispanic Origin? (n, Mexican, Pue Specify: ation furing most of we 18. Mother's Na Gertrud and Number or F	Specify Yes or Nordo Rican, etc.) brking me (First, Middle.)	10g. Citizen United 14. F Spe 16b. Kind o Steel Maiden Sum	of What Cour State Race - Americ Black, White, orify: Whi Business/In-	ng to n od. Inside Ci 1 □ Yes ntry? Sean Indian, etc. te	D.C.
Was Decedent Ever in U. Armed Forces? 1	Isa. Decedent (Give kint life. DO Machine 19b. Mailing A 381 Blc Place of Disposition commetery, cremate 1 crest M.	10f. Zip Code 21032 s Decedent of Hies, specify Cubai lyes 210 No It's Usual Occupa d of work done of NOT use retired, Operato	Specify: ation furing most of we r 18. Mother's Na Gertrud and Number or F	Specify Yes or Nordo Rican, etc.) brking me (First, Middle.)	10g. Citizen United 14. F Spe 16b. Kind o Steel Maiden Sum	of What Cour State Race - Americ Black, White, acify: Whi Business/Inc	od. Inside Ci 1 □ Yes http: Sean Indian, etc. te dustry	ty Limits
Was Decedent Ever in U. Armed Forces? 1	Isa. Decedent (Give kint life. DO Machine 19b. Mailing A 381 Blc Place of Disposition commetery, cremate 1 crest M.	10f. Zip Code 21032 s Decedent of Hi es, specify Cubai Yes 21 No It's Usual Occupa d of work done of NOT use retired, Operato	Specify: ation furing most of we r 18. Mother's Na Gertrud and Number or F	Specify Yes or Norto Rican, etc.) orking me (First, Middle.)	United 14. E Spe 16b. Kind o Steel Maiden Surr	of What Cour State Race - Americ Black, White, Blocky: Whi Business/Inc	1 □Yes ntry? S can Indian, etc. te dustry	
Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates: Ion Ompleted) College (1-4or 5+) Print) Print) 20b. P	15a. Decedent (Give kinter DO Machine 19b. Mailing A 381 Blc Place of Disposition commetery, cremate 1 1 crest M.	21032 s Decedent of Hises, specify Cubar lyes 2 No t's Usual Occupa d of work done of NOT use retired, Operato Address (Street a	Specify: ation furing most of we r 18. Mother's Na Gertrud and Number or F	Specify Yes or Norto Rican, etc.) orking me (First, Middle.)	United 14. E Spe 16b. Kind o Steel Maiden Surr	State Race - Americ Black, White, Hocity: Whi Business/In-	can Indian, etc.	
Armed Forces? 1	15a. Decedent (Give kint life. DO) Machine 19b. Mailing A 381 Blc Place of Disposition commetery, cremate 1 1 crest M.	s Decedent of Hies, specify Cubar Yes 2X No I's Usual Occupa d of work done of NOT use retired, Operato Address (Street a	Specify: ation furing most of we r 18. Mother's Na Gertrud and Number or F	Specify Yes or No rio Rican, etc.) orking ume (First, Middle.)	Spe 16b. Kind o Steel Maiden Surr	Race - Americ Black, White, ocity: Whi f Business/In Manufa	can Indian, etc. te dustry	
Armed Forces? 1	16a. Decedent (Give kink. iife. DO) Machine 19b. Mailing A 381 B1c Place of Dispositic commetery, cremate 1 crest M	t's Usual Occupa d of work done a NOT use retired, Operato Address (Street a	Specify: ation furing most of we r 18. Mother's Na Gertrud and Number or F	orking me (First, Middle, e Tribby	Spe 16b. Kind o Steel Maiden Surr	Black, White, ocity: Whi Business/In Manufa	etc. te dustry	
1 Yes 2 M No If Yes, Give Year or Dates: on	16a. Decedent (Give kink. iife. DO) Machine 19b. Mailing A 381 B1c Place of Dispositic commetery, cremate 1 crest M	t's Usual Occupa d of work done a NOT use retired, Operato Address (Street a	Specify: ation furing most of we r 18. Mother's Na Gertrud and Number or F	orking me (First, Middle, e Tribby	Spe 16b. Kind o Steel Maiden Surr	ocity: Whi t Business/In Manufa	te dustry	
Print) 20b. Proval from State	Machine 19b. Mailing A 381 Blc Place of Dispositic commetery, cremate 1 crest M	of work done of NOT use retired, Operato Address (Street a	turing most of we or 18. Mother's Na Gertrud and Number or F	ıme (First, Middle. e Tribby	S teel Maiden Surr	Manufa		
Print) 20b. P oval from State	Machine 19b. Mailing A 381 Blc Place of Dispositic commetery, cremate 1 crest M	of work done of NOT use retired, Operato Address (Street a	turing most of we or 18. Mother's Na Gertrud and Number or F	ıme (First, Middle. e Tribby	S teel Maiden Surr	Manufa		
Print) Print) 20b. P	19b. Mailing A 381 Blc Place of Disposition commetery, cremate 1 crest M	Address (Street a	18. Mother's Na Gertrud and Number or F	me (First, Middle). e Tribby	Maiden Surr		cture	
er 20b. P	381 Blo Place of Disposition commetery, cremate 1 crest M	Address (Street a	Gertrud and Number or F	e Tribby		name)		
er 20b. P	381 Blo Place of Disposition commetery, cremate 1 crest M	Address (Street a	and Number or F	e Tribby	O: . T			
er 20b. P	381 Blo Place of Disposition commetery, cremate 1 crest M	Address (Street a	and Number or F	lural Route Numbe	O': T			
oval from State	lcrest M	ossom Tr						
	lcrest M		ee Driv	e Annapo	lis,	Maryla	nd 214	01
hii		ory or otner place	<i>θ)</i>					
)	22 N	ame and Addres		2/2004				
PTEN			٠.	ohn M. Ta				
ions that caused the deat				ester St.		abolis	Approximat	9
cause on each line.							Interval Bet Onset and I	
Due to (or as a conseq	quence of):	1 1		1		-		
COYOT	1074	Hrt	OYY	Dist	eas-	9		
Due to (or as a conseq	quence of):	6-1-1	1					
Duo to transport	JI- J	1.alo	e7t					
Due to or s a conseq	quence or):							
	V							
If yes, outcome of pregna	ancy				23d	Date of delive	arv	
4☐Pregnant at time of d							,	/ear
9□ Unknown								
outing to death but not res	sulting in the unde	erlying cause give	en in Part I.	23e. Did to	obacco use c	ontribute to th	ne cause of d	eath?
(Vasc	u/ar	DIS	ease	1	es 2□No	3 Prob	ably 4 🗀	inknown
						b. Were auto	psy findings	available
						death?		
			26. Place of De	ath (Check only o	ne)			
1 inpatient 2		3 DOA	4 Vivursing				y)	
28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work	ζ?	28d. Describe h	now injury occ	curred		
28e Place of Injury - At h	ome farm street		162 5 140	28f. Location (5	Street and Nu	mber or Rum	il Route Num	har
building, etc. (Specif	fy)	, lactory, office		City or Tox	m, State)	moor or rigin	11 110010 110111	JG/,
On the basis of examina and manner stated.	ation and/or invest	stigation, in my op	pinion, death occ	curred at the time,	Date and place	e, and due to	the cause(s)
Also	. 1	29c. License	number	02	29d. Date sig	ned (Month,	Day, Year)	
1/1/0/0/	MD	1,000	186	85	/	111	104	
plefted cause of death (Item	m 23a) (Type, Prir	nt) 8700	(e)	itral	AG	ve,	Swit	e30
		LANIT	DOVE	Ky My	2) (200	195	/
D 1	Dital: 1	4 Pregnant at time of death 5 0 0 9 Unknown outing to death but not resulting in the under the	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown 1 Inpatient 2 EP/Outpatient 3 DOA Other (specify) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury World 1 Death of	1	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) outing to death but not resulting in the underlying cause given in Part I. 23e. Did to 24a. Was autop performed at 1 Impatient 2 ER/Outpatient 3 DOA other: 4 Dursing Home 5 Resident Amounts of Injury (Month, Day Year) 28b. Time of Injury Month, Day Year) 28c. Injury at 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Scity or Townson and To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cand manner stated.	1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (specify)		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1- State of Maryland / De State of Maryland / De C	partment of Health and r ertificate of Death	Mental Hygle Reg.	- ^ ^		
	Physici		Decedent's Name (First, Middle, Last) Robert Eugene Hech1	er Sr.	2. Date of Death Month January	Day Year 7 2004 2:24 P. M		
	/Medic Examir		4e. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	·	4c. County of Death		
		ς	612 Drain Avenue		Anne Arundel			
	Funeral Director		5. Social Security Number 6. Sex 7. Age (<i>In yrs. last birthda</i> 21.2 36 3597 12⊠ M 2□ F 64 Yrs.	y If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye March 16,	9. Birthplace (State or Foreign Country) 1939 Maryland		
	and and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits		
	he Maryl 8a-f sho	Director	Maryland Anne Arundel Pasade	·		1 ☐ Yes 2X No		
	ath with the 23a or 2	rai Dire	10e. Street and Number 612 Drain Avenue	10f. Zip Code 21122		Citizen of What Country? U.S.A.		
21215-0036	72 hours after death with the Maryland natural; or items 23a or 28a-f show dical Exemirat remait be motified at	d by Funerai	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 1956— If Yes, Give Year or Dates: 1960	 Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2X No Specify: 	pecify Yes or No- p Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White		
5-0	72 hours "natural", alical Ex	etec	15. Decedent's Education 16a. De (Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of work . DO NOT use retired)	king 16t	b. Kind of Business/Industry		
121	within ene. than	Completed	Elementary/Secondary (0-12) College (1-4or 5+) LO	. DO NOT use retired) Cksmith		Locksmith		
Maryland 2	be filed ntal Hyg od othe event,	To Be C	17. Father's Name (First, Middle, Last) Harold Hechler		ne (First, Middle, Mai na Shaffer	den Sumame)		
ary	S D E E	-	19a. Informant's Name/Relationship (Type, Print) 19b. Ma	ural Route Number, City or Town, State, Zip Code)				
	2 # 20 L				sadena, M	aryland 21122		
Baltimore,	Pages lent of nt: If it		Talbunal 2 Cremation 3 Chemoval nois state	position (Name of rematory or other place) dge Mem. Park 1/10		Location - City or Town, State		
Balt	permit. Pag Department Important: any injury once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Georg 4001 Ritchie Highw	ge J. Gond	ce Funeral Home, P.A. More, Maryland 21225		
	Physician /Medical Examiner	ier	23a. Part1. Enter the disease, or complications that caused the death. Do not on shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	inter the mode of dying, such as cardiac as toma Mu	or respiratory arrest,	Approximate Interval Between Onset and Oeath 2 2 2 3 4 4 5 6 6 7 7 8 7 8 8 8 8 9 9 9 9 9 9 9 9 9		
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	ledicai Examin	resulting in death) Last Due to (or as a consequence of): d.	tenfon.				
P.O. Box	that the death certi ed by the attending detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown		23d. Date of delivery Month Day Year			
	w requires that been signed t should be deta	Ď	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	2 No 3 Probably 4 Duknown		
of Vital Records,	ian: The law r rificate has be tor, page 2 sh	Completed			24a. Was an autopsy performed 1 Yes 2 🗹			
/ita	Physician: rthis certifica ral director, I	Be	25. Was case referred to medical examiner?	0.1	h (Check only one)			
of	Physi this c	၉	1			6 ☐Other (Specify)		
Division	e te	Certification;	1 Natural 5 Pending (Month, Day Yeer) Injury 2 Accident investigation	Work? M 1 □ Yes 2 □ No	28d. Describe how it			
DİVİ	ital or At Irs after d ral Direct led in by	Certifi	4 Homicide determined 200. Place of Injury - At nome, farm, building, etc. (Specify)	City or Town, Si				
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the cause red at the time, date	e(s) and manner as stated. and place, and due to the cause(s)		
)	To the vithin 2 To the complei	×	29b. Signature and title of certifier	29c. License number 1 14136		Date signed (Month, Day, Year)		
1	1001			/\`	201 Gle	'n Burniz, MD2104		
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 1 3 2004	South		•		
DH	MH 17 Rev 1/2	001						

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** Charles Walter Hediger 5:24 P.M 2004 January 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 3614 West Bay Avenue Baltimore If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Min. Months Days Hours 1**⊠** M 2□ F 82 August Illinois 343 12 1881 **Director** Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, it a Medical Exaction must be notified at 1XYes 2 No Director Maryland N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3614 West Bay Avenue 21225 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 X Yes 2 □ No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Crown Oil Company 6th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental Hitant: If item 27 is marked oth Be Charles F. Hediger Anda M. Dresch ျ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Darnise Frey / Niece 905 Beech Street Highland, Illinois 62249 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. MD State Veteran Cem. 1/14/2004 | Crownsville, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Faction Feorge J. Gonce Funeral Home, P.A. 21. Signature of Funeral Service License 4001 Ritchie Highway Baltimore, Maryland 21225 ameralista 2.3. Part1. Enter the disease, resp. clications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List say one cause on each line. Approximate Interval Betw Immediate Cause (Final ARTERY CORONARY **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4□Pregnant at time of death 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 90 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1 ☐ Yes 2 ☐ No 1 Tyes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No 2 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) si Hanava st. 0001, Anita Khancle (was M) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 3 2004 CHARLE

DHMH 17 Rev 1/2001

Registrar

Charles and

			For State Registrar	State	of Marylan	id / Depa <i>Cer</i>	artment o	of He	ealth a Death	and M	ental Hy	giene Reg. No.	200		วงป
	Physicia		1. Decedent's Name (First, Middle	, Last)	dak						2. Date of Dea Month	Day	7 200 c	3. Time of De	eath M
	/Medic Examin		4a. Facility Name (If not institution	give street and nu Beaverbr	ook Corner		4b. City, To	own, or L	ocation o		olumbia	-	County of Deat	Howard	
	Funeral Director		5. Social Security Number 047.05.8380	6. Sex 1 ☐ M 28 F	7. Age (In yrs.	last birthday) 90 Yrs.	tf Under 1	Year Days	If Under :	24 Hrs. Min.	8. Date of Birt (Month, Da) Septemb	v, Year)	Co	hptace (State or F untry) Connectic	
	show	o.	Usual Residence of Decedent 10a. State 10b. County Maryland	Howard	10c. Cit	ty, Town or Lo	cation	(Colum	bia				10d. Inside City	\
	with the Marylar a or 28a-f show	Direct	10e. Street and Number 5245 Hayledge Co	ourt			10f. Zip C	ode	2	1045		10g. Citizen of What Cou U			`
25	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Health and Mental Hygiene. or other traumatic event, the Medical Examinar must be incitibed at or other traumatic event.	by Funeral Director	11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced	12. Was Dec Armed For ed 1 Yes If Yes, Gi Year or D	edent Ever in U orces? 2X No ive Dates:		_	nt of His y Cuban No	panic Orig , Mexican Specify:	gin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White			
20070	d within 72 ho piene. r then "netur the Medical I	Completed	15. Decedent (Specify only highes Elementary/Secondary (9-12)	t grade completed)	(1-4or 5+)	(Give	dent's Usual (kind of work DO NOT use	done du retired)	ion uring mosi omema		ng	16b. Kind of Business/Indu Own I			
ומוומי	permit. Pages 1 and 2 should be filed within Department of Health and Mehall Hygiene. Important: If Itam 27 is marked other than any injury or other traumatic event, Itam Nonce.	To Be C	17. Father's Name (First, Middle,	Last) George Elko)			1	18. Mothe	r's Name	ne (First, Middle, Maiden Sumame) Bertha Biled				,
, Mai	and 2 sho ealth and h m 27 is me	•	19a. Informant's Name/Relations Mr. John Hud		Son 5245 Hayledge Court Colum				il Route Numbe umbia, Mai	Route Number, City or Town, State, 2 nbia, Maryland 21045					
	Part L		20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		,	St.	John's C	er place, emet	ery	0.	1/13/2004	20c. Loc	cation - City or Stratt	Town, Stata ord, Conn.	
משור	permit. Pa Departmen Important: any Injury once.		21. Signature of Funeral Service	John	Moize	931		38/1 (Old Co	lumbia	PIKE EIIIC		y, MD 210	43	
	Physician /Medical Examiner		23a. Part1. Enter the diseage, of shock, or heart failure. List Immediate Cause (Finat disease or condition resulting in death)	a	each line.	rtine		^			or respiratory ar	rest,		Approximate Interval Betwee Onset and De	
=		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	(or as a consec	quence of):									
,007	e be execu rsician and e burial-tra	ical Exar	that initiated events resulting in death) Last C. Due to (or as a consequence of):												
O. BOX 60	The law requires that the death certificate be executed site has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi										23d. Date of delivery Month Day Y			ar
cords, r	quires that n signed by uld be deta	þ	Part II. Other significant condition	ons contributing to	death but not res	sulting in the u	nderlying cau	ise giver	n in Part I.			obacco us		the cause of dea	
ב	The lay	Completed									24a. Was autop perfo 1 \(\text{Yes} \)		24b. Were au prior to death? 1 □ Yes	itopsy findings av completion of cau	ailable se of
	ician: certific rector,	Be	25. Was case referred to medica examiner?	Hospital:] ER/Outpatier		Dther			(Check only o		₹ 13. 15	hed Live	1
5	g Physer this eral di	n; To	1 ☐ Yes 2 2 No 27. Manner of Death	28a. Date		28b. Time of		c. Injury			me 5 Resident		Other (Spe cocurred	city)	
JIVISION	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Diractor: After this certifics completely filled in by the funeral director, it	Certification:	Natural 5 Pendir 2 Accident investi 3 Suicide 6 Could 4 Homicide determ	gation not be 28e. Place	e of Injury - At h	ome, farm, str	М	1 🗆 Y	es 2 🔲		28f. Location (S City or Tov	Street and	Number or Ru	ıral Route Numbe	or,
_	To the Hospital or within 24 hours affe To the Funeral Dir completely filled in	edical Ce		ng Physician: To the Examiner: On the and mai											
	To the within To the comple	Me	29b. Signature and title of centiling		Com		29c. I	License) 3 G	number	,		29d. Date	o signed (Mont	h, Day, Year)	
	D		30. Name and address of person	who completed cau		m 23a) (Type,	Print) 1994	B	enzi	· b o :	krd,	AUL	umbia.	mg 2i	044
ř	Sta	ate	31. Date filed (Month, Day, Year)	3 2004 32.	Registrar's Sign		book	,		-					

	A	mei	nd Item #16,per FH,	G827, State	of Marylar 2004,gap	nd / Depa <i>Cer</i>	rtment of H tificate of I	lealth and M Death	lental Hyg	iene g. No.	104	00	1531
			1. Decedent's Name (First, Midd	le, Last)					2. Dete of Deet Month	h Day	Year	3. Time o	of Death
	Physicia /Medica		Gilbert Henry	Ironmonge	er				January			02:30	O PM
	Examine		4e Fecility Neme (If not institutio	n, give street end n	um <i>ber)</i>		4	lb. City, Town, or Lo	ocetion of Deeth	4c. County	of Death		
		ĸ	1045 7th Stre	et				Glen Burn	***	Anne			
	Funeral		5. Social Security Number	6. Sex 34☐ M 2☐ F	7. Age (In yrs. 7.5		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day,	Yeer)	9. Birthp Coun	iace (State try)	or Foreign
	Director		220-24-5767	N⊒ W 2⊟ !	13	Yrs.			Sept 2,	1928	Balti	imore	, MD
	bra ¥	+	Usuel Residence of Decedent 10a. Stete 10b. County	,	10c. Ci	ty, Town or Loc	ation				1	0d. Inside (City Limits
	Many	ō	MD Anne	Arunde1		len Bur	nio					1 ☐ Ye	s 2√2 No
	28a	<u>ခို</u>	10e. Street end Number			ich bul	10f. Zip Code		1	0g. Citizen of V	Vhat Coun	try?	
	3a or	Funeral Director	1045 7th Stree	+			21060			TICA			
	death	era F	11. Mantal Status	12. Wes De	cedent Ever in U	J,S. 13. W	as Decedent of Hi	ispanic Origin? (Sp	ecify Yes or No-		e - Americ		
Maryland 21215-0020	within 72 hours after death with the Maryland ene. than "natural" or items 23a or 28a-f show he Madical Examinar must be notified at	by Fur	1 ☐ Never Married 2 ☐ Mer	If Yes. G	2∛⊡ No iive			n, Mexican, Puerto Specify:	orto Rican, etc.) Black, V Specify: W				
ō	2 hor	Completed		nt's Education	,	16e. Deced	ent's Usual Occupa	ation		16b. Kind of Bu	ısiness/Inc	lustry	
215	E E	<u>e</u>	(Specify only higher Elementary/Secondary (0-12)	st grade completed	(1-4or 5+)	life. D	O NOT use retired	during most of work ()	ing				
7	filed within Hygiene. other than ant, the M	ĕ	Ziomontaly/observatory (o 12)	2		Elect	ritian E	lectrician		Defens	e Cor	itract	tor
2	産工学を	Be	17. Father's Name (First, Middle,	Last)				18. Mother's Name	e (First, Middle, M	Maiden Surnam	ie)		
<u> </u>		0	Henry W. Ironmo	nger				Julia I	. Bolton	1			
a	and s m		19e. Informant's Name/Relations	ship (Type, Print)		19b. Mailing	g Address (Street a	and Number or Run	al Route Number	City or Town,	Stete, Zip	Code)	
2	D € ► ₹	1.0	Mrs. Gail Prevo	st / Daug				et Glen					
ore	S = 0	1	20a. Method of Disposition 1 □ Burial 2 X Cremation	3 □Removal from	20b. I	Place of Dispos cemetery, crem	sition (Name of atory or other plac	:e) T	Date an 17	20c. Location -	City or To	wn, State	
Ĕ	Pages ment of ant: If Its ury or o		4 Donation 5 Other (S			esapeak	e Cremat	ion	2004	Steve	nsvil	le, M	4D
Baltimore,	permit. Page Department (Important: if any injury or page.		21. Signature of Fune at Service	Licensee	LA		Name and Address	ss of Facility Funeral H		Secon Glen E			
_		٦	23a art. Ent. the disease, o shock, or heart tal ure. List	r complications that only one cause on	caused the dea each line.	th. Do not ente	r the mode of dyin	g, such as cardiac	or respiratory arre	est,	ļ ŧ	Approxima Interval Be Onset and	etween
	Physician /Medical	1	Immediate Cause (Final	P	0.1055	-,, 5	0110.	omyo Pi	4 ~ 7 . 34		1	454	115
	Examiner	70	diseese or condition resulting in death)	a				Orn 40 F	4177			7607	~)
		<u>ē</u>			Due to (or as a consequ	lence oi):				ŀ		
	be executed sician and burial-transit	Sequentially list conditions, if any, leading to immediate any leading to immediate and leading											
ó	an an rial-tr		Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying		,			1					
8760,	physiciant the pu	8	Cause (Disease or injury that initieted events	C	Due to (c	or as a consequ	ence of):						
•	The law requires that the death certificate be executed ite has been signed by the attending physician and page 2 should be detached for use as the burial-transit	B	resulting in death) Last	L							1		
Box	eath certific attending for use as	Pnysician/Me		0					v		1		
0.	the a	SIC	Pert II. Other significant condition	ons contributing to	death but not res	sulting in the un	derlying cause give	en in Part I.	23b. Did to	bacco use cor	ntribute to	the cause	of death?
9.	that the		CEREBLOV	ASCUL A	2 DIS	SEASES	-		1 □ Ye	s 2 No	3 Prob	ably 45	Unknown
ds,	signe d be	2							24a. Was a	n autoney	24h We	ere autopsy	v findings
Ö	v require	616							perform		ave	npletion of	r to
of Vital Records,	has b	Completed								4.1		death?	
<u>=</u>									1 ☐ Ye		1 L	Yes 2	_ No
Σ	Physicisn: this certific ral director,	O De	25. Was case referred to medica examiner?	Hospital:		1==10	3 DOA Othe	er:					
	Phys this ral dir	- -	1 ☐ Yes 2 🔼 No 27. Manner of Deeth	11	Inpatient 2 of Injury oth, Day Year)	ER/Outpetient 28b. Time of	28c. Injun Work	4 Li Nursing Ho	me 5 Reside)	
o	ding th. th. After funer		1 Natural 5 Pendir 2 Accident investi		nth, Day Year)	Injury		k? Yes 2 □ No					
Division	i or Attending after death. Director: After d in by the fune	Certification:	3 Suicide 6 Could 4 Homicide determ		- 101	28f. Location (St. City or Town		er or Rura	Route Nu	m <i>b</i> er,			
_	Hospi 24 hou Funer tely fill	edical C		ng Physician: To the Examiner: On the I)(s)
	within 2 To the comple		29b. Signature and title of certifie				29c. License	e number	25	9d. Date signe	d (Month, I	Day, Yeer)	
			1/3° Cu	Walla	ce hu	(3)	D31	136	1	ANUAR	4 /2	200	24
	•		30. Neme end eddress of person	who completed cau			Print)		1 1		- /		
	20		BRIAN Can	ALLACE	, mi	9005	KILB	136 RIDE K	LOAD, NO	TTINOH	Am.	(m)	21236
100	State Registra		31. Dete filed (Month, Day, Year,	N 1 3 200	Registre Sign	ature	Sports.	7	,		1		

State of Maryland / Department of Health and Mental Hygiene

					Olate of	Maryia				Death	ı wemanı	Reg. No. 2	004	-	15.32
	Dhugiei		1. Decedent's Name (/								2. Dete of D		Yeer	3. Time	of Death
	Physicia /Medic		Sr. Sever	nine An	thony I	pri					Januar		04	7:00	AM
	Examin	er	4a Fecility Neme (If no The Vi		street end num	nber)				4b. City, Town, Balti	or Locetion of Dea .more		nty of Deeth	re	
	Funeral Director	Ĭ	5. Social Security Num 326-07-52	54 1	ex □M 2]X]F	7. Age (In yrs. 92		If Under Months	1 Year Days	If Under 24 H Hours N	lin. 8. Date of Bi (Month, D Feb 16	th ay, Year) , 1911		olace (Stat ntry) nsylv	e or Foreign an i a
	and		Usuel Residence of De 10a. State 10	Ob. County		10c. Cit	ty, Town or Lo	cation					1	0d. Inside	City Limits
	Mary a-f she	ţo	MD	Baltimo	re		Bal	Ltimo	re						es 2√∏No
	th with the 23a or 28	Funeral Director	10e. Street end Number		enue			10f. Zip	Code 2121	2		10g. Citizen d USA		ntry?	
020	permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Maryland Department of Heatth and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Examination must be notified at once.	by Funer	11. Marital Status 1 ☒ Never Merried 3 ☐ Widowed 4 ☐		12. Was Dece Armed For 1 Yes If Yes, Give Year or Da	ces? 2 [X] No e	l I			lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)	Spec	lace - Americ lack, White, city: Wh		
5-0	natu dice	etec		. Decedent's Ed only highest gree			16e. Deced (Give	ent's Usua kind of wor	l Occup	ation during most of v	vorking	16b. Kind of	Business/In	dustry	
Maryland 21215-0020	ed within /giena.	Completed by	Elementary/Seconda		College (1-	4or 5+)		eache		1)		relig	ious e	ducat	ion
/land	uld be fill Mental Hy rked oth tic even	To Be	17. Fether's Name (Fire Antonio I								_{lame (First, Middle} ia Theodo		,	-	
	nd 2 sho lith and A 27 is me r traume		19a. Informant's Name Sr. Vicki			erg 1001 W. Joppa Road B					. , , ,				
Baltimore,	Pages 1 and and of Hee Int: If Item arry or other		20a. Method of Disposi 1 ☐ Burial 2 ☐ C 4 🎇 Donation 5 ☐	remation 3 🗆			Place of Disposemetery, crem	sition (Nam netory or ot	ne of ther plac	ee)	Date	20c. Location	n - City or To	wn, State	
Balt	permit. Departrimporta any Inje		21. Signeture of Funer	al Service Licent		rd 655 W. 201	Balti:	more S	tree	İ					
1	Physician /Medical Examiner	er	23a. Parl 1. Enter the c shock, or heart fa Immediate Cause (Find disease or condition resulting in death)			heroscl		Card			iac or respiratory a		1	Approxim Interval B Onset an	etween d Death
x 68760,	The law requires that the death certificate be executed at has been signed by the attending physician and paga 2 should be datached for use as the burlal-fransit	/Medical Examiner	Sequentially list conditi if any, leading to imme cause. Enter Underlyin Cause (Disease or inju- that initiated events resulting in death) Last		b		r as a consequ	,							
s, P.O. Box	ras that the daath ce igned by the attendir ba datached for use	by Physician/M	Part II. Other significar	nt conditions co	ntributing to dee	th but not resu	ulting in the un	derlying ca	use giv	en in Part I.		tobacco use d Yes 2☑No			of death?
of Vital Records,	a law requira has been sig ga 2 should b	Completed									24a. Was perfo	an autopsy rmed?	cor	re autops ilable prio npletion of death?	/ findings r to cause
a			OF Was	to man a direct								res 20 No	10	Yes 2	√No
Ξ	siclar certif	o Be	25. Was case referred the examiner? 1 ☐ Yes 2 ☑ No	-	Hospitel:	patient 2	ER/Outpatient	a□ nc	Oth		eath (Check only o				
1 of	g Phys er this eral di	2	27. Manner of Deeth		28a. Date of		28b. Time of		Bc. Injury Work	4 Ezi Nursing	Home 5 Resident			"	
Division	al or Attending Physician: s after death. I Director: After this certific d in by the funeral director,	Certification:	2 Accident	Pending investigation Could not be determined	28e. Place o		Injury me, farm, stre	М	10	Yes 2□No	28f. Location (S		nber or Rura	Route Nu	mber,
	Hospi 4 hou Funer taly fill	29a. Certifier (Check only one) 29a Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause of the caus								ated. the cause	(s)				
_	To the Within 2 To the comple	ž	29b. Signature and title	of certifier				29c.	License	number		29d. Date sign	ed (Month, L	Day, Year)	
			mi	2n - Pon	/ K.	venp	/mg		0 3	1865	`	1/3	104		
			30. Name end eddress					rint)	1 ^	0	hd ?				
	b % C.		Rm 206 31. Dete filed (Month, D			staw 5 pistrer's Signat		() ()	ali	Thore	ma	100/			
	State	e	\$ M. 3		14	Calle A	y Ga								

			1 - For State Registrar	State	of Maryla			of Heal		fental Hyg	iene , eg. No.	2001		
4	Dharalai	1	1. Decedent's Name (First, Middle, L	.ast)						2. Date of Dea	h Day	Year	3. Time of Death	
4	Physici /Medic		Catherine		L.		Jo	nes		Januar		2004	12:30a [™]	
	Examin		4a. Facility Name (If not institution, g	ive street and no	umber)		4b. City, T	own, or Loca	ition of Death		4c. Co	ounty of Deat	h	
		4	3205 Burleith					imor						
	Funeral			Sex 1□M XXF		s. last birthday) Yrs.			inder 24 Hrs. Jurs Min.	8. Date of Birth (Month, Day	Year)	Co	hplace (State or Foreign nuntry)	
ti.	Director		216-30-1002 Usual Residence of Decedent	7111	71	113.			<u> </u>	07 07	32		MD	
	land bw		10a. State 10b. County		10c. (City, Town or Lo	cation					10d. Inside City Limit		
	Mary -feh	tor	MD NA		Ba	altimo	re					XXYes 2 □ No		
	1 the	Director	10e. Street and Number				10f. Zip 0	Code		1	g. Citizen of What Country?			
	h with		3205 Burleith	Ave				2121	5		U S A			
	deat	Funerai	11. Marital Status		cedent Ever in	U.S. 13. \	Was Decede	nt of Hispani		ecify Yes or No-	14	Race - Ame Black, White		
ပ္	or Ite		1 Never Married 2 Married		2(X\o		1 Yes 2		ecify:	riicari, e(c.)		pecify: B1	_	
2	und.	d by	3 Widowed 4 □ Divorced	Year or	Dates:						3,	Decity. 111	Lack	
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "naturel", or itema 23a or 28a-f ehow event. It a Madical Examinar niust bu multired at	Completed	15. Decedent's (Specify only highest g	Education trade completed)	(Give	dent's Usual kind of work DO NOT use	done durina	most of work	ing	16b. Kind	of Business/	Industry	
2	Mithin ane. Than	m	Elementary/Secondary (0-12)		(1-4or 5+)				- d -	4	a h .a	II on led	na Haaniba	
N	Hygie Hygie other	င္ပ	12th grade 17. Father's Name (First, Middle, Las	na st)		ned.	rca1	Recor		e (First, Middle, I			ns Hospita	
aŭ	lid be flental l	œ												
Maryland	s 1 and 2 should be f Health and Mental item 27 is marked other traumatic ev	은	Richard Willia 19a. Informant's Name/Relationship			19b. Mailir	na Address (.lliams al Route Number	City or T	nwn State 2	Zin Code)	
<u>8</u>	d2 s th an trau		Nathaniel Jone		Son					Baltim	•		21215	
a)	Health Health tem 27 other tr	1	20a. Method of Disposition		20b	. Place of Dispo	sition (Name	of		-		tion - City or		
<u>no</u>			XXBurial 2 Cremation 3 4 Donation 5 Other (Spec	☐Removal from		cemetery, cren	•		1	1 /1 0 /0		Torrison Balancaria	200	
altimore,	permit. Page Department of Important: If eny injury or once.		21. Signature of Funeral Service Lic		A1	CDUTUS 22	Memo Name and	rial Address of F	Park Facility Ma	1/13/0 rch F/H	4 Ar Wes	butus	Md	
ä	Per Per Per Per Per Per Per Per Per Per		Co Sala Mi	nich									to, Md 21215	
		m	23a. Part 1. Enter the disease, or co shock, or heart failure. List on	mplications that	caused the de	ath. Do not ent	er the mode	of dying, suc					Approximate	
	Physician -		Immediate Cause (Final	ry one cause on	each line.		ance					1	Interval Between Onset and Death	
	/Medical		disease or condition resulting in death)	a. Due to	o (or as a cons	equence of):	Crice	-1						
	Examiner													
F		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	o (or as a cons	equence of):								
	cuted nd ransi	Examin	that initiated events	c										
Ó,	e exe ian a urial-1	EX	resulting in death) Last	Due to	Due to (or as a consequence of):									
8760,	cate be executed physician and the burial-transit	d												
9		Φ.	IF FEMALE:									1		
Вох	the death certific y the attending p tched for use as	Physician/M	23b. Was decedent pregnant in the past 12 menths?	1 ☐ Live	utcome of preg birth 2 ☐ Fe	etal death 3	Ectopic pre				230	I. Date of deli Month	very Day Year	
o.	t the de by the a tached f	sic	1 ☐ Yes 2 MNo 9 ☐ Unknown	4∐Preg 9□ Unki	gnant at time o nown	fdeath 5∟	Other (spe	cify)					34, . 34.	
<u>a</u> .	that the ed by detac		Part II. Other significant conditions	contributing to	death but not r	esulting in the ur	nderlying car	ise diven in f	Part I	23e Did tot	acco use	contribute to	the cause of death?	
Records,	se ng es	1 by				300 til. 19 til. 19 til	raony mg oan	sso given ii i	are i.		s 2 🗆 f			
Ö	w requir been si should	etec								-				
ş	e law has b	Completed								24a. Was a autops perform	y .	24b. Were au prior to death?	topsy findings available completion of cause of	
a	₩ ⊶									1 ☐ Yes 2	No	1 🗆 Yes	20 No	
Vital	ding Physician: After this certifications of the director.	Be	25. Was case referred to medical examiner?	Hospital:	•					n (Check only on				
ō	Phys this rat di	2	1 Yes 2 No 27. Manner of De th	1	Inpatient 2 of Injury	☐ ER/Outpatien 28b. Time of		c. Injury at	Nursing Ho	me Reside 28d. Describe ho			oify)	
S	ding Afte fune	tlon	1 Natural 5 ☐ Pending	(Mo.	nth, Day Year)		м	Work? 1 ☐ Yes		200, 2000, 200 110	w injury o	0041104		
Division	or Attending after death. Director: After in by the fune	Certification:	3 Suicide 6 Could not	be one place	e of Injury - At	home, farm, str				28f. Location (St.	reet and N	lumber or Ru	ral Route Number,	
<u> </u>	after Dire	erti	4 Homicide	buili	ding, etc. (Spe	cify)				City or Town	, State)			
_	spita nours neral filled		29a. Certifier Certifying I	Physician: To th	ne best of my k	nowledge, death	occurred at	the time, da	ite and place.	and due to the ca	iuse(s) an	d manner as	stated.	
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	(Check only 2 Medical Exone)	aminer: On the	basis of exami nner stated.	nation and/or inv	vestigation, i	n my opinion	, death occurr	ed at the time, da	ite and pla	ace, and due	to the cause(s)	
	Withir To th	Me	29b. Signature and title of certifier	1 1			29c.	License num	ber	2		igned (Month		
	1		Sulve 161	25/			JI	2370	57		ano	cary,	7,2004	
	(-)		30. Name and address of person wh	o completed car	use of death (It	em 23a) (Type,	Print)	Dive -	al.	71	7		7,2004	
	1		Deba / Went	Leine	-10	243	4601	ik	ele	we I	a/5	0,1	2/2/2/5	
100	Sta		31. Date filed (Month, Day, Year)		Registrar's Sig	nature	116.2	21						
	Registr	ar	IAN 13	2004		H A	and a							

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** AY JONES 4:55 4 M 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMERE SAMARIAN HOIPIAL GOOD BATTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Month Cay 1956 Birthplace (State or Foreign Control yland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 10 M 20 F 220-64-8947 47 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Baltimore Marvland N/A 1 Yes 2 No Director 10g. Citizen of What Country? U.S.A. 10e. Street and Number 10f Zip Code or Items 23a or 21216 1046 Ellicott Dr death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Inpopartment of Health and Mental Hygiene. If tiem 27 is marked other than "natural", or ther event the second process. 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Black Baltimore, Maryland 21215-0036 Specify: Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Verizon Co. Elementary/Secondary (0-12) College (1-4or 5+) Collection Division 12 18. Mother's Name (First, Middle, Maiden Sumame, Lorean E. Perry 17. Father's Name (First, Middle, Last) Be Clarence Jones ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1046 Ellicott Dr Baltimore, Maryland 21216 19a. Informant's Name/Relationship (Type, Print) Terrell Clay Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c Location - City or Town State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 01/12/04 Landsdown, Maryland Mt. Zion * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Estep Brothers Funeral Home P.A. 1300 Eutaw Place Baltimore, MD 21217 21. Signaturejof Funeral Service Licensee Estes ecsa 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) 1 Yes 2VINO 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ should be ON CHRONIC RENALFAILURE 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 has autopsy performed? certificate 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes P No 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation **U** ■ Natural 1 ☐ Yes 2 ☐ No death. 2 🗆 Accident the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C the Hospital *Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier D0060687 · (hamas MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAMARITAN HOSPITAL AS MD MON 600D 31. Date filed (Month, Day, Year) Registrar's Mnature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 0450 AM Janet P. Klock ANUARY 2004 /Medical 4a. Facility Name (If not institution, give street and number). 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE LI
If Under 1 Year | If Under 24 Hrs.
Hours | Min. BALTIMURE DINAI PITAL OF 5. Social Security Number 7. Age (In yrs. last birthday) 76 Yrs. 8. Date of Birth (Month, Day, Feb. 8, 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 M 2X F Days 226-28-2206 Virginia Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow other traumatic avent, the Medical Examiner must be notified at Yes 2□No Maryland N/A Baltimore Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4323 Newport Avenue 21211 Itетs 23a USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 202 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married Married 5 1 Yes XX No Specify: Maryland 21215-0036 Specify: ģ 3 ☐ Widowed 4 ☐ Divorced white natural Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than . Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any nigury or other traumatic avent, Ite Mones. Office Manager Electronics Industry 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Winston Poff Ethel Hall 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earl M. Klock 4323 Newport Avenue (husband) Baltimore, Maryland 21211 more. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State Dulaney Valley Memorial 1/12/04 Timonium, Maryland `4 ☐ Donation 5 ☐ Other (Specify) 21. Signatu Peral Service/Lice See 22 Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 21211 And State and St Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition -cpatorenal Lyndrome Physician 30 dups resulting in death) /Medical Due to (or as a consequence of): Examiner nahhis \subset He Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of): Examiner The law requires that the death certificate be executed 20400-1 andtrans Hypertension to (or as a consequence of): signed by the attending physicien a d be detached for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Live -0 1 1 Yes 2 No 3 Probably 4 Unknown Completed peen Melli 24b. Were autopsy findings available prior to completion of cause of death? Diabetes 24a. Was an has autopsy page performed' this certificate 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No ₽ 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification; 1/ Natural 5 Pending within 24 hours arie;
To the Funeral Director; Aft investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 5 Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier fo the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MO RES-UOU Junuary 8, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Belvedere Avene Bolkhore MD 21215 200 A 32. Redistrar's Signature Nian 31. Date filed (Month, Des Year) State Registrar

			State of Maryland / Department of Health and N		•	
			Registrar Certificate of Death	Reg.	No.	00000
	Physic	ian	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death
	/Medi		Alice Lee Krause	January	12,2004	0216 м
	Examir	ner	4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death	_
			Upper Chesapeake Medical Center Belair 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8 Date of Birth	Harfor	
	Funeral Director		217-14-6802 1□ M 2¼F 82 Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 12/2/192	21 Vira	ace (State or Foreign ry) inia
	pug 🛦 🗎		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			d. Inside City Limits
	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Madical Examples institled at once.	5	MD Harford Street			1 Tyes 2 No
9	r 28a-	Director	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Count	
216	h with		3514 Burkins Road 21154	T	JSA	
0	deat	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		14. Race - America	
0	after of the	显	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 ☑ No Specify:	nican, etc.)	Black, White, e	
	Maryland 21215-0036 nd 2 should be filed within 72 hours aft the and Mantal Hygiene. 27 is marked other than "natural", or traumatic event, the Madical Extraint	d by	3 ¼ Wildowed 4 □ Divorced Year or Dates:		Specify: Whit	
	15-	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of work life. Do NOT use retired)	ing 16b	. Kind of Business/Ind	ustry
	V12	E	Sementary/Secondary (0-12) College (1-4or 5+) 3rd College (1-4or 5+) Assembly Line work		Western	Electric
00	offied other	Be C		e (First, Middle, Maid	den Sumame)	
2	/lar	ToE	Barney Davis Maude	Pillsb	ury	
1/12/04	lary 2 sho and 1 is me		19a. Informant's Name/Relationship (Type, Print) daughter	al Route Number, Cit	ty or Town, State, Zip	Co <i>d</i> e)
-	and and lealth m 27 her tr		Sandra Lee Pitzer 3514 Burkins Rd.,			
	JOFE ges 1 If ite or oth		cemetery, crematory or other place)		Location - City or Tov	
	Baltimore, oemit. Pages 1 ar Department of Hea mportant: If item: any injury or other once.		21.00		Balrimore	
	Bal permi Depar impor any ir		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Jo 263 S. Conkling	seph N. St. Balt	Zannino imore, M	Jr. FH D 21224
			23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)			Onset and Death
	/Medical Examiner	ı	Due to (or as a consequence of):			
7		<u>_</u>	Sequentially list conditions, if any, leading to immediate gause. Enter Underlying			
	uted s insit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.			
2622	Box 68760, eath certificate be executed attending physician and for use as the burial-transit	Exa	resulting in death) Last Due to (or as a consequence of):			
36	760, rte be ex rysician ne burial	cal	d			24 (242)
#0	ox 68 certificat nding phy	Med	IF FEMALE:	_		
	Box sath cer attendin for use	ian/	23b. Was decedent pregnant in the past 12 months? 1 □ Live birth 2 □ Fetel death 3 □ Ectopic pregnancy		23d. Date of deliver	y Day Year
	• 13 10	Physician/Med	1 □ Yes 2 ☑ No 9 □ Unknown 5 □ Other (specify)		IVOITU .	Jay I Gai
0.1	P.O.		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to the	cause of death?
9	rds quires n sign	d by	CORONARY ARTERY DISEASE	1 ☐ Yes	2 □ No 3 □ Proba	bly 4 Unknown
1	ecol law rec as bee 2 shou	ojete	DEMENTA	24a. Was an	24b. Were autop	sy findings available
N	of Vital Records, Physician: The law requires t this certificate has been signe tal director, page 2 should be	Completed		autopsy performed? 1 ☐ Yes 2 🔀	? death?	pletion of cause of
Ü	ital	Be C	25. Was case referred to medical examiner? 26. Place of Death	h (Check only one)	(0)	
Alic	of Vita Physician: this certific	2	1 ☐ Yes 2 No Hospital: 1 Hnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Ho		6 ☐Other (Specify)	
1	on of ding Phys	in o	11⊠Natural 5 □ Pending (Month, Day Year) Injury Work? _	28d. Describe how in	njury occurred	
a'	Division or Attending after death. Director: Afte	icat	2 Accident investigation 3 Suicide 6 Could niced determined determ	28f Location /Street	and Number or Rural	Pouto Numbos
3	Div A after Direct Dire	Certification:	4 Homicide determined building, etc. (Specify)	City or Town, Sta	ate)	Houle Number,
Krause	Division of Vital Revision Structure of Vital Revision of Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier (Check only Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred.	and due to the cause ed at the time, date a	e(s) and manner as sta and place, and due to t	ted. he cause(s)
X	thin 2 the complete	Medicai	one) and manner stated. 29b. Signature and tittle of/gentifjer/ 29c. License number		Date signed (Month, D	
	7. w. 7.		MARGA RANC MAX N. 95737	~ .	/IIA CE I *	, T * 11
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1741	VUTRY 12	, 2004
			VIJAY M. ASHYAWKAR & NORTH AVENUE	BELA	TR Mb a	21014
	Sta Registi		31. Date filed (Month, Day, Year) JAN 1 3 2004 32. Registrar's Signature			

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** GARRY KNOTTS Januar 7,2004 6020 M /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hospita Baltimore maryland Genera If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) Funeral Days 1**∑**M 2□ F Months 187-54-5564 38 Director 10/01/1965 PA Usuel Residence of Decedent 10c. City, Town or Location BALTIMORE 10a. State 10b. County 10d. Inside City Limits or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at MD N/A 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 USA 2330 MARYLAND AVENUE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Specify: Specify: BLACK Completed by 3 ☐ Widowed 4 ☐ Divorced marked other than 'natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) **JANITOR** J.H.H. HOUSEKEEPING 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Sumame) Pages 1 and 2 should be fill iment of Health and Mental Hitant: If Item 27 Is marked oth EARLINE MILTON KNOTTS TONY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 S. JANNEY ST., BALTO., MD 21224 BARRY KNOTTS/BROTHER 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State ortant: If I 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State METRO CREMATORY permit. Page Department of Important: If sny injury or once. 01/12/04 BALTIMORE, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC ames 4. 1701 LAURENS ST., BALTO., MD 21217 23a. Pert / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) **Physician** Meumonia /Medical Examiner Immunodeficiency Virus sacus nitally list concrious if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed ntravenou Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Dinknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an is after deau...
ral Director: After this co...
a in by the funeral director, pa 1 ☐ Yes 2 2 No 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 phpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funeral L 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) mane 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) General hom be id a 31. Date filed (Month, Day, Year) 32. Aegistrar's Signature State Registrar JAN 1 3 2004

				State of M	arylan	•			lealth a <i>Death</i>	and M	fental Hy	/gie Reg.	/11	G4	G.	1508
	Physicia /Medica		1. Decedent's Name (First, Middle, Last) HAZEL KOSCI	ELSKI							2. Dete of D Month JAN .		Dey 2004	Year	3. Tim	e of Death
À.	Examine		4e Fecility Neme (If not institution, give						4b. City, To	wn, or Lo	ocation of Dee	th	4c. County			
	Funeral Director	8	GENESIS ELDERCA 5. Social Security Number 218-09-9905 6. Security Number			CENT last birthday) Yrs.		er 1 Year S Deys	SILV If Under Hours	24 Hrs. Min.	SPRING 8. Date of B (Month, D APR.	irth ey, Ye	er)			ite o <i>r Foreig</i> n
	pue ≱	-	Usuel Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Loc	ation									e City Limits
	Manyla	ō	MD MONTGO	OMERY		ILVER		RTNG								res 2∭No
	th the	<u>s</u>	10e. Street end Number					ip Code				10g.	Citizen of W	Vhat Cour	itry?	
	ath wi	ā	3227 BEL PRE RO					2090					U.S.			
920	ours efter death with the Marylen elt, or terms 23a or 28e-f ehow Evarrainer must be notified at	by Funeral Director	11. Maritel Status 1 Never Married 2 Married 3 Vidowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 27 If Yes, Give Year or Dates:		If	Yes, sp	edent of Hecify Cube	lispanic Orig en, Mexican Specify:	gin? (Sp , Puerto	ecify Yes or N Rican, etc.)	0-		k, White,	an Indian etc. LTE	i,
21215-0036	d within 72 hours efter death with the Maryland piene. Then "naturel", or frems 23s or 28e-f show the Medical Examiner must be notified at	Completed	15. Decedent's Edu (Specify only highest grade Elementery/Secondary (0-12)		5+)	16e. Decede (Give k life. D			ation during most d)	of work	ing		Kind of Bu	siness/In	dustry	
d 2			17. Father's Neme (First, Middle, Lest)			CUSTO	DIF	N_	18. Mothe	r's Nam	e (First, Middle				7.	
ılan		o Be	JOHN POLITOWI	TZ					LEC	KAD	IA B	ULC	ZYNS	ΚI		
Maryland	0 6 6		19a. Informant's Name/Reletionship (Ty				,				al Route Numi				,	
	s 1 and 2 of Health Item 27 I		VIRGINIA LYONS/ 20a. Method of Disposition	DAUGHTE		1315	FF	ANKI	IN S	T,N	.E., W.		INGT Location -			
Baltimore,	00		1 □XBuriel 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	lemoval from State	C	emetery, crem	atory of	other place	•	1 //1						
altir	permit. Peges Depertment of Important: If II any Injury or o		21. Signature of Funeral Service License	ee	OAI	C LAWN	Name	and Addre	ss of Facilit	v	4/04			•		YLAND
ä	Den and Den			1							INC. I					D
			23a. Part1. Enter the diseese, or complishock, or heart failure. List only or	ications that caused ne cause on each li	the deat									1	Approxir Interval	mate Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	CORON		ARTE			EASE					 	Onset a	nd Death
		Je		FATTI		r es a consequ ГО THR								į		
o,	icate be executed physician end s the buriel-transit	Examine	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury)TAILU		r es e consequ										
68760,		edical	Cause (Disease or injury that initiated events resulting in death) Last)	Due to (or	r as e consequ	ence of):								
Box	eeth certifi attending I for use es	and a	d	1										<u> </u>		
	the at	Physician/M	Part II. Other eignificant conditions con	tributing to death b	ut not resi	ulting in the un-	derlying	cause giv	en in Part I.		23b. Did	tobac	co use con	tribute to	the cau	ee of death?
, P.O	thet the de ned by the a detached t										1	Yee	2 No	3 🗆 Prol	pably 4	! □ Unknown
of Vital Records,	S Dag .	Completed by									24a. Was	an au ormed	utopsy	co	ere eutop eilable pri mpletion deeth?	sy findings ior to of cause
Re	The lavelete has	E									10	Yes	2 No	1 🗆	∃Yes 2	No.
/ita		g R	25. Was case referred to medical examiner?							of Deat	n (Check only	оле)	/ \			
d	를 를 다.	<u> </u>	1 ☐ Yes 2 No			ER/Outpatient 28b. Time of	3 🗆 [4 /A NU		me 5 Res				1)	
Division	ath. rr: After	Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28a. Date of Inju	y Year)	Injury	M		k? Yes 2 ☐ f	No	28d. Describe				J Pouts A	lumbar
Div	To the Hospital or Attend within 24 hours efter deatt To the Funeral Director: completely filled in by the	Certi	4 Homicide determined	28e. Place of Inj building, et	c. (Specif)	() 					City or To	wn, St	ete)			uniber,
	Hospital 24 hours Funeral etely filled	edicai	29a. Certifier (Check only one) Certifying Phys Medical Examir	ner: On the besis of end manner st	examine	wiedge, death tion end/or inve	estigation	n, in my o	ne, date and pinion, deat	h occurr	end due to the ed et the time,	date a	e(s) and mar and place, a	nner as si ind due to	ated. the caus	ie(s)
	To the To the comple	2	29b. Signature and title of certifier	101			2	9c. Licens	e number			29d.	Date signed	(Month,	Day, Yea	r)
			Douma	ILLO	m	ray	Y) I	5896	55			J	TAN.	12,2	2004	
7	7	- 1	30. Name end address of person who co			23e) (Type, P	rint)							2780		
	5		SAIMA KHAWAJA, M. 31. Dete filed (Month, Day, Year)	D. 111	_	ROCKVI	LLE	PIK	E,ST	Ε	100, RC	CK	VILLI	E,MD	. 20)852
	State	e		n anna	P.S. T.	20	639	well)	•							

DHMH 16 Rev 6/95

ORIGINAL

•	1 - State Registrar	State of Maryl		artment of H rtificate of			iene 20	04 005.
ian	1. Decedent's Name (First, Middle, Last,					2. Date of Deat Month	th Day Y	3. Time of Death
cal		Joseph A. Ko	bester	45 Cit T-11-	of continued Dec	January		
ner	4a. Fecility Name (If not institution, give				or Location of Dea	ith	4c. County of	
	5. Social Security Number 6. Sec		yrs. last birthday)	If Under 1 Year	Burnie	S. 8 Date of Birth		e Arundel
		M 2□F 8		Months Days	Hours Mir	8. Date of Birth (Month, Day, March 8	,1919	9. Birthplece (State or Foreign Country) Kansas
	Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or Lo	ncation				10d. Inside City Limits
ō	Maryland Anne Ar		Glen Bu	_				1 ☐ Yes 2 X No
Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wh	at Country?
	268 Glen Gary Ga	arth		21	061		U.S.	A.
by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 🌠 No If Yes, Give Year or Dates:		Was Decedent of HITYes, specify Cub		Specify Yes or No- rto Rican, etc.)		American Indian, White, etc. White
eted	15. Decedent's Edu	cation e completed)	(Give	dent's Usual Occup	during most of we	orking	16b. Kind of Busin	ness/Industry
Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 2 years	life.	DO NOT use retired Sonnel	d)	-	Dept. of	Defense
င္ပ	17. Father's Name (First, Middle, Last)	2 years	101	Somer	18. Mother's Na	ime (First, Middle, M		20101100
To Be		. Koester	19h Maili	ng Address (Street	Mary	/ H. Dijk Rural Route Number		ate Zin Code)
11	Anthony Koester			Broadvie				r, MD 21401
	20a. Method of Disposition	1	b. Place of Dispo cemetery, crei	osition (Name of matory or other plan	се)	Date :	20c. Location - Ci	ty or Town, State
	1 ☑ Burial 2 ☐ Cremation 3 ☐ F `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		11 Cemets		3/2004	Baltimor	e, Maryland
	21. Signature of Funeral Service License	Klage						eral Home, P.A Maryland 21225
dicai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or what) that initiated events resulting in death) Last	Due to (or as a con Due to (or as a con Due to (or as a con	sequence of):	vaocul		1000		5 /1100 1
Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	3c. If yes, outcome of pre 1 □ Live birth 2 □ I 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of Month	
þ	Part II. Other significant conditions cor	ntributing to death but not	resulting in the u	nderlying cause giv	en in Part I.			ite to the cause of death? ☐ Probably 4 ☐ Unknown
Completed						24a. Was ar autops perform 1 Yes 2	prio ned? dea	re autopsy findings available r to completion of cause of th? Yes 2 \sum No
Be C	25. Was case referred to medical				26. Place of De	ath (Check only one		.03 22 110
ToE	examiner? 1 ☐ Yes 2 ☑ No		2 ER/Outpatien	at 3□ DOA Oth		Home 5 Heside	át:	(Specify)
	27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Yea	r) 28b. Time of Injury	Wor	y at	28d. Describe ho		
Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp.	necify)			City or Town	, State)	or Rural Route Number,
	29a. Certifier 1 Certifying Phys	sicien: To the best of my	knowledge, death	n occurred at the tir vestigation, in my o	ne, date and plac pinion, death occ	e, and due to the ca urred at the time, da	use(s) and manne ite and place, and	er as stated. I due to the cause(s)
dicai	(Check only 2 Medical Examinations)	and manner stated.						
Medical	(Check only 2 Medical Exami	and manner stated.	2	29c. Licens	e number	29		Month, Day, Year)
Medical	one)	mpleted cause of death	3	Print)	13/5	urnie, Mai	19nua	12,2004

		•	1 - For State Registrar	State of Marylan	d / Department of H		Mental Hygie	2.16.	
	Physici /Medic		1. Decedent's Name (First, Middle, Las	"Lawson			2. Date of Death	Day 2004	3. Time of Death
	Examin Funeral Director		4a. Fecility Name (If not institution, give Chenes S E der 5. Sociel Security Number 6. Sc 2 12 - 20 - 5 (83) Usual Residence of Decedent	Care-Caton	Manor Bal	or Location of Deeth	8. Date of Birth Month, Day, Ye	4c. County of Deeth	A place (State or Foreign ntry) RYYANA
	a-f show	ctor	10a. State 10b. County	10c. Cit	y, Town or Location Baltimore				10d. Inside City Limits 1 ✓ Yes 2 ☐ No
036	72 hours after death with the Maryland natural', or Items 23s or 28s-f show ileal Eracul ver must be motified at	by Funeral Director	10e. Street and Number 3002 We S 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 Yes 2 MNo If Yes, Give Year or Dates:	10f, Zip Code 2 13. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 1 No			Citizen of What Cou	can Indian,
21215-0036	c 2	Completed by	15. Decedent's Ed (Specify only highest gra		16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	pation during most of work d)	king 16b	o. Kind of Business/Ir	ndustry
Maryland 2	should be filed within and Mental Hygiene. I marked other than umatic event, If a Mi	To Be Co	17. Father's Name (First, Middle, Last) Walter Ch	affin	Domeste	18. Mother's Nam Ella	Tohn	den Sumame)	ammes
	es 1 and 2 : of Health ar if item 27 is or other trau		19a. Informant's Name/Relationship (7) NrS. Brenda 20a. Method of Disposition 10 Burial 2 Cremation 3 Company 4 Donation 5 Other (Specify	Johnson Removal from State	Place of Disposition (Name of semetery, crematory or other place	stwood	Ave I	ity or Town, State, Zi	1d. 21216
Baltimore,	permit. Pag Department Important: I sny injury o		21. Signature of Funeral Service Licen	1111	122. Name and Address JOSEPH L. 2222 W.	iss of Facility RCISS NOTH A	Funeral	Home Md. 21	216
-	Physician /Medical Examiner		23a. Part Enter the disease, or company to shoot, or heart fallure. List only disease or condition resulting in death)	aDue to (or as a conseq	Styre Has wence of): Navy Anto	ng, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
8760,	ate be executed sysician and he burial-transit	icai Examiner	S puential vist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq c. Due to (or as a conseq d.					
O. Box 6	The law requires that the death certificate be executed tto has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	I death 3 Ectopic pregnancy	,		23d. Date of deliv Month	ery Day Year
٥.	n requires that been signed b should be deta	þ	Part II. Other significant conditions of	- 0	ulting in the underlying cause giv	ven in Part I.		co use contribute to t	he cause of death?
al Records,		Completed					24a. Was an autopsy performed 1 ☐ Yes 2 ☐	prior to co	opsy findings available impletion of cause of
ion of Vital	ing Phys After this uneral dir	tion: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatient 2 I	28b. Time of 28c. Injury Work	ner: 4 Horsing Ho	th (Check only one) ome 5 Residence 28d. Describe how in		(y)
Division	ital or Attendii irs after death. ral Director: A led in by the fu	Certification:	3 Suicide 6 Could not be determined	building, etc. (Specify			City or Town, Si		
	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by i	Medical	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam 29b. Signature and title of certifier	vsician: To the best of my kno iner: On the basis of examina and manner stated	wiledge death occurred at the tin tion and/or investigation, in my o	opinion, death occur	red at the time, date	e(s) and manner as s and place, and due to Date signed (Month,	o the cause(s)
	meson		30. Name and address of person who	completed cause of death (Item			5 Eng	/	
Þ	Sta Registr	- 3	31. Date filed (Month, Day, Year)	1 3 200 Pegistrar Signa	ature II Agent	meno	5 Ferry	, Rel	13 Aur)

Anne lame (If not institution, g. nt Josepharity Number 683699 ance of Decedent 10b. County	B. give street and number h Medica	er)	Lane				2. Date of D Month JANUA	Day		r	Time of Death
ame (If not institution, g. nt Joseph upity Number 6 6—3699 ence of Decedent	give street and number h Medica. S. Sex 7. //	er)	Lane					4 K Y			THE SHAPE SHAPE
unity Number 62646-3699 ence of Decedent	h Medica:			4b Ciby	Town or	Location of Dea			. County of D		0:20
ence of Decedent		ı Ceni	ter	4D. City,	TOWN, OI	Tow		40.		ltim	ore
ence of Decedent	1 □ M 2 💢 F	Age (In yrs. Ia		If Under Months	1 Year Days	If Under 24 Hr Hours Mir		irth ey, Yeer)	9. 8	Birthplace Country)	(Stete or Fore
10b. County		85	Yrs.				May 7,			w Yo	rk
		10c. City	, Town or Loc	cation						10d. Ir	nside City Lim
and St. J	Johns		St. Au	gust	ine					1	☐Yes 2🌠
nd Number				10f. Zip	Code			10g. Citi	izen of Whal	Country?	
AlA South #		-t Evenie 11 0	C 40.14		2080	i- Os-i-2 (Canada Van an N		JSA 14. Race - A		dian
tatus er Married 2 ☐ Married	12. Was Deceder Armed Force 1 Yes 25	s?	5. 13. V	Yes, spec	cify Cuba	spanic Origin? (n, Mexican, Pue	Specify Yes or N rto Rican, etc.)	0-	Black, W		dian,
owed 4 Divorced	If Yes, Give Year or Dates		1	☐ Yes	2₹ No	Specify:			Specify:	Vhite	
15. Decedeni's (Specify only highest of			16a. Deced	ent's Usua	al Occupa	ation Juring most of w	orkina	16b. Ki	ind of Busine		
y/Secondary (0-12)	College (1-4c	or 5+)	life. D	OO NOT us	se retired)		Fo	ood & I	rug	
2 Name (First, Middle, La	5+		Consu	mer A	Affa	irs Spec			lminist	rati	on
							ıme (First, Middle	э, маюэл	_		
e S ant's Name/Relationship	Kelly p (Type, Print)		19b. Mailine	a Address	(Street a	Cather and Number or F	LITE Iural Route Numb	oer. City o	Flyr or Town, State		e)
M. Lane /							gh, Nor				605
of Disposition	•		ace of Dispos	sition (Nan	ne of	-	Date	20c. Lo	ocation - City		
ial 2 □ Cremation 3 e xton , 5 □ Other <i>(Spe</i>		19				Cemete:	13, 200 rv		Ltimore	. Ma	rvland
joi Tuneral Service Lic	cease Co	1					ome of Du				
Bryan W. C1	lary	7	X	0 W.	Pado	onia Roa	id, Timo	nium,	MD 2	21093	11C •
Enter the disease, or co or heat failure. List on	omplications that caus nly one caus a on each	sed the death. n line.	. Do not ente	r the mod	e of dying	, such as cardia	ic or respiratory a	arrest,		Inter	roximate rval Between
Cause Final	a ISCHE	HIC I	HEART	DIS	EASI	ores No. o				Ons	et and Death
death)	Due to (or a	as a consequ	ience of):							3 175° A 110	-15:22
list conditions,	b. Due to (or s	as a conseque	ence of):								
r Underlying	200 10 (01	u	orios ory.								
events death) Last	C. Due to (or a	as a conseque	ence of):						· · · · · · · · · · · · · · · · · · ·	-	
	d										
					- 101						
ecedent pregnant		2 Fetal	death 3 1	Ectopic pr	egnancy			2	23d. Date of d Month	lelivery Day	Year
ast 12 months? s 2 2 No known	4□ Pregnant 9□ Unknown	at time of dea	ath 5	Other (sp	ecify)				MOHIII	Day	real
significant conditions	s contributing to death	but not resul	iting in the un	derlying c	ausa diva	n in Part I.	23e. Did	tobacco u	se contribute	to the cau	use of death?
			•	, , ,	•		1 🗆	Yes 2]No 3□	Probably	4 Unknow
							24a. Was	20	24h Were	autoney fir	ndings availab
							auto	psy ormed?	prior to	o completi	ion of cause o
e referred to medical						26 Place of De	ath (Check only	2∐ No	11500	es 2 🗆 t	40
2 No	Hospital: 1 VInpa	atient 2 E	ER/Outpatient	3 DO	A Othe		Home 5 Res		3 □Other (Sc	ecify)	
of Death	28a. Die of In		28b. Time of Injury	2	8c. Injury Work	at	28d. Describe			//	
ral 5 ☐ Pending dent investigat	tion		,,	М		es 2 □ No					
ide 6 Could not nicide determine	ad 200. Place of I	Injury - Al honetc. (Specify)	me, farm, stre	et, factory	, office		28f. Location (City or To	Street and wn, State)	d Number or i	Rural Rou	te Number,
	<u> </u>										
r 1.2% Certifying i only 2. ☐ Medical Ex	caminer: On the basis	of examination	vledge, death ion and/or inve	occurred a estigation,	at the tim in my op	e, date and plac inion, death occ	e, and due to the urred at the time,	cause(s) date and	and manner and de	as stated. ue to the c	ause(s)
re and little of certifier	and manner	statou.		29c	. License	number		29d. Date	e signed (Moi	nth, Dev. 1	Year)
	,										/
Tho	U	f death (Item	22a) /Tuna B	,	D mil	oc.44		'		- 1	
Ha	ho completed cause of			error 1							
	y 2∐ Medical E	and manner of and little of gertifier	2 Medical Examiner; On the basis of examination and manner stated. and manner stated.	2 Medical Examiner: On the basis of examination and/or invited manner stated.	2 Medical Examiner: On the basis of examination and/or investigation, and manner stated. 29c	2 Medical Examiner: On the basis of examination and/or investigation, in my op and manner stated. 29c. License	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occard manner stated. 29c. License number D 28244	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, and manner stated. 29c. License number D 28244	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and and manner stated. 29c. License number 29d. Dat	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and diand manner stated. 29c. License number 29d. Date signed (Month of Cartifier) 29d. Date signed (Month of Cartifier) 29d. Date signed (Month of Cartifier)	and manner stated. 29c. License number 29d. Date signed (Month, Dey, 1)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death cedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 6 ATHANI ANUARY 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. Coonty of Deeth Examiner umoR 6A3 10 7. Age (In yrs. last birthday) 5 Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 MM 2 □ F 226 968 Director 30 URRGINIX Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director CATUNSUICE Sp/ Ame 15 marylows 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? AIRIDGE 21207 1412 USA or items 23a CZAD Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 1940 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural". 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) rthan Elementary/Secondary (0-12) College (1-4or 5+) f Health and Mental Hygiene item 27 is marked other than 1215 grade Specialis 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WAZTEN chinn LBME 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 818 Manlonso 1 mis 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1⊌Burial 2 □ Cremation 3 □ Removal from State Consten ¹ 4 □ Donation 5 □ Other (Specify) 1851/E 21. Signature of Funeral Service Licent 22. Name and Address of Facility C Striften KARD unarl BUCHA MeryLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one my selon each line. Approximate Interval Between Onliet and Death Immediate Cause (Final disease or condition Physician OAK 101 resulting in death) /Medical Due to (or a) a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed as the burial-transit that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy jo Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown has been signed by Part II. Ather significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 No 3 Probably 4 | Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy certificate 2 No 25. Was se referred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) To Other: 4 Nursing Home 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 5 esidence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No death. investigation 2 Accident in by the thin 24 hours after death To the Funeral Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies 23a) (Type, Pret) 31. Date filed (Month, Day, Y 3 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month 2004 LUCAS Jan. 6:30 a M C5512 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12 St. Thomas Lane Owings Mills Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth Month, Day (ear) 10, 1922 North Carolina 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 ☐ XF 81 Yrs. 243-30-2826 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show item 27 is marked other than "natural", or Items 23a or 28e-f shor other traumatic event, if a Madical Examinar must be indiffed at Maryland Baltimore 1 Yes 2 No Director Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12 St. Thomas Lane 21117 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 Z No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Midowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than "in any injury or other traumatic expense. Elementary/Secondary (0-12) College (1-4or 5+) 12 Cafeteria Worker Baltimore Co. Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ٥ William Baldwin Viola Marsh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4810 Stafford St., Baltimore, Md. 21229 Gertrude Lucas - sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) LakeView Mem. Park Jan. 13,2004 Sykesville, Md. 22. Name and Address of Facility
Eckhardt Funeral Chapel P.A.
11605 Reisterstown Rd. Owings Mills, Md. 21. Signature of Funeral Service Licensee Held 21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** spiration pnesmonia week /Medical Due to (or as a consequence of) Examiner phag Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of); Physician/Medical Examiner physicien and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 for use as the the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 4 Pregnant at time of death 5 Other (specify) P.O. 1 detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ page 2 should be 2 No 3 Probably 4 Unknown 1 □ Yes Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2 710 of Vital 1 Yes 2 ☑ No 1 TYes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending death. 1 Tes 2 No investigation 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Medical 📝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated c. mpletely (Check only one) 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. veithin 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2004 cause of death (Item 23a) (Type, Print) 30. Name and address of person who completes Startin m achard teranacci DO 315 D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State The state of Registrar 3 2004

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dey January 8, Richard Albert Lyne 2004 3:30 AM 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Neme (If not institution, give street end number) Fagewood If Under 1 Year If Under 24 Hrs. Harford 2322 Perry Avenue 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (Stete or Foreign Country) Days Hours M 2□ F 82 21, 1921 Pennsylvania 159-16-7256 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Harford Edgewood 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 2322 Perry Ave. 21040 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Miles roces: Marcha Pes 2□No Korea Marcha Pes Sive Marcha Pes Vietnam 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☐ No Specify 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) Colonel U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Albert Henry Lyne Anna Matilda Anderson 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Highview Memorial Gardens 1-10-04 Fallston, Maryland

Richard M. Lyne / Son 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility McComas Funeral Home, P.A. 21. Signature of Funeral Service Licenses 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part T. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Completed by Funeral Director

Funeral

Director

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

Immediate Cause (Final

disease or condition resulting in death)

heimer's Due to (or es a consequence of):

Kinson's Due to (or es e consequence of)

Approximate Interval Between Onset end Death

days

Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the ceuse of deeth? 3 Probably 4 Unknown 1 Yas 2 No

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 Tho

26.	Place of	Death	(Check	only	one)	

1 ☐ Yes 2 No

25.	Was case	to	medical
	examiner?		
-	1000		

27. Manner of Death 5 Pending investigation 1 Naturel 2 Accident 3 ☐ Suicide

6 Could not be

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year)

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

Other: 4□ Nursing Home 5 → esidence 6 □Other (Specify) 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one)

31. Date filed (Month, Day, Year)

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29b. Signature end title of certifier

29d. Date signed (Month. Dav. Year)

under Thune

Hospital:

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) inder Stephanie

State Registrar

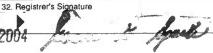
DHMH 16 Rev 6/95

24 hours aftar daath.

within 2

Abspital

fillad in by



ORIGINAL

permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28e-f show any Injury or other than the Mental Research of man be notified at any Injury or other traumatic event, I'm Medical Exertine I man be notified at

Maryland 21215-0020

usa as the bunal-transit

Be Completed by Physician/Medical Examiner

Medical Certification: To

or Attending Physician: The law requiras that the death certificate be executed Division of Vital Records, P.O. Box 68760,

			1 - For State Registrar	State of Mary			nt of Health an te of Death	d Mental H	ygien Reg. N	1/1/1/	4 005,6
			Decedent's Name (First, Middle, Las	1)				2. Date of I			3. Time of Death
	Physici		DAVID J	AMES	Lo	12 V	550	Month	Li	ay Year	23=41 M
100	/Medic Examir	_	4a. Facility Name (If not institution, give	street and number)		4b. City	, Town, or Location of D	Death	4	c. County of Dea	ath
E.	LAGITI		EL UPPER CHESA	PEAKE ME	MICHEC	ENT	br 362	A-1-2		HARA	020
- 64 1	Funeral		5. Social Security Number 6. Se	7. Age (II	n yrs. last birthday		r 1 Year If Under 24	Hrs. 8, Date of I	Birth Dey, Year	9. Bi	rthplace (State or Foreign country)
4	Director		189-44-5133 ½	M 2 F	50 Yrs.	Wortens	Days	Apr.		1	7irginia
	р.		Usual Residence of Decedent 10a, State 10b, County	10	Oc. City, Town or L	contine					10d. Inside City Limits
	aryla shov	-	10a. State 10b. County		oc. City, Town of L	ocation					1 ☐ Yes 2½ No
	Ra-f	octo	Maryland Harford	l	Stree	-			1.0		
	or 2	Director	10e. Street and Number				ip Code		10g. C	itizen of What C	ountry?
	ath v		1110 Poplar Grov				21154			USA	
	d within 72 hours after death with the Maryland Jiene. r than "natural", or tems 23a or 28a-f show the Madical Exemirat must be nutified at	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Dec If Yes, sp	edent of Hispanic Origin ecify Cuban, Mexican, F	Puerto Rican, etc.)	NO-	14. Race - Am Black, Wh	
36	s aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2√ No If Yes, Give Year or Dates:		1 🗌 Yes	2☐√No Specify:			Specify:	T.T. i L.
21215-0036	tural F.E.E.E.E.E.E.E.E.E.E.E.E.E.E.E.E.E.E.E		15. Decedent's Ed		16a Dece	adent's Us	ual Occupation		16b.	Kind of Busines	White
15	n 72	Completed	(Specify only highest gra-	de completed)	(Give	e kind of w	ork done during most or use retired)	f working	100.		
12	within ene. then	m	Elementary/Secondary (0-12)	College (1-4or 5+)	Flec	ctric	a l		7.1	utomotiv	70
9	Hygent, and,	Ö	17. Father's Name (First, Middle, Last)		TILC C	LLIC		Name (First, Midd			
Maryland	Mental Mental Merked c	To B	Vincent Albert	Lorusso			Eliza	beth C	laire	e Rymar	1
<u> </u>	d 2 should be th and Mental 7 is marked (traumatic ev	F	19a. Informant's Name/Relationship (7		19b. Mail	ing Addre	ss (Street and Number of				
\mathbf{z}	ロモトコ	Ì			111	n po	olar Cucus	Dond Ct		MD 21	154
ē,	-195		Patricia Iorusso 20a. Method of Disposition	o/ Wife	20b. Place of Disp	osition (N	plar Grove ame of other place)	Date Date	20c.	ocation - City o	
9	Pages nent of int: If it		1 ⊠Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify	Hallioval Itotti State							Pennsylvania
Baltimore,	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licen							er con,	Permsy I varita
Ba	Dep trap		Italia (1	Morrale			and Address of Facility as Funeral Cokesbury R			n MD 21	nna
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the						1, 110 21	Approximate Interval Between
1	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)		onsequence of):	zy A	nteny o) SEAS	<u>-</u>		Onset and Death
8760,	death certificate be executed e attending physician and id for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, feating to ammodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a co							
O. Box 6	death certif	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	□Ectopic □ Other (pregnancy specify)		-	23d. Date of de Month	elivery Day Year
ص	The law requires that the tte has been signed by the bage 2 should be detache		Part II. Other significant conditions of	ontributing to death but n	ot resulting in the	underlying	cause given in Part 1.	23e. Di	d tobacco	use contribute	to the cause of death?
of Vital Records,	w requires t been signe should be	d by						1[] Yes	2 □ No 3 □ F	Probably 4 Unknown
Ö	w req	Completed						24a. W	as an	24b. Were a	autopsy findings available
Re	The la ate has page 2	Ĕ				-		ре	topsy rformed?	prior to death?	completion of cause of
ā		Ö	25. Was case referred to medical				26 Place of	Death (Check onl	2 (3E N	1 1 1 1 1 1	s 2 No
5	Physician: this certificant ral director.	o B	examiner?	Hospital:	2/NER/Outpatie	ent 3□ 0		ing Home 5 Re	100	6 Other (Sn	acity)
of		H .	27. Manner of Death	28a. Date of Injury	28b. Time	of	28c. Injury at	28d. Describ			вену)
on	ding Ith. Th. After funer	ţ	1 Natural 5 Pending 2 Accident investigation	(Month, Day Y	ea <i>r)</i> Injury	М	Work? 1 ☐ Yes 2 ☐ No				
Division	er dear	Certification:	3 Suicide 6 Could not be determined		- At home, farm, s Specify)	treet, facto	ory, office	28f. Location City or	(Street a Town, Sta	and Number or F te)	Rural Route Number,
7/	Hospi 4 hour Funer ely fille	edical C		ysician: To the best of niner: On the basis of example and manner stated	amination and/or i						
	To tha within 2 To the complet	Me	29b. Signature and title of certifier	1		2	9c. License number		29d. D	ate signed (Mor	nth, Dey, Year)
	1		> gameshi r	I Am	M.D DIT	=	0 11809		.) ^	. ~ 4	2004
	10	Total Assessment of the Control of t	30. Name and address of person who	completed cause of deat	h (Item 23a) (Type	Print)				4	
	l		95P2A34U			اد ال	O Timor	ion M	0 7	21093	
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's		- Control	D				
	Regist		IAI	1 1 3 2004	No all and a	de	Someth !				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 30 PM LAZUR MARY 2004 JAN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner NIA BALTINORE GARDENVIlle RD If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 321 1235 26,1906 **Director** 180-03-Usuat Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other fraumatic event, the Michael Examples nettilized at once. 10a. State 10b. County 10 Yes 2 No BALTIMORE Completed by Funeral Director MD 10g. Citizen of What Country? 10e. Street and Number GARDENVIlle RD 21206 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□ Yes 2☑No Baltimore, Maryland 21215-0036 Specify: Specify: WhiTe 3. Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coltege (1-4or 5+) CLERK BAKERY 12 4 Ala 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be GREVERA MARTHG UNKNOWN JOHN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto. Mo 21206 5611 GARdenville RD. VAetH BARBARA . A. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Burial 2 ☐ Cremation 3 ☐ Removal from State 112 04 Holy Redeemer Cem. 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility
HARTLEY MILLER - STELLA FURKE
7527 har Ford RD. Balto. MO STELLA FUNERAL HOME CHTD. 21. Sanature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat PNEUMONI **Physician** Week disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner TOYEARS BRONCHITIS CHRONIC Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed for use as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 St No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, been signe should be d ONGESTIVE HEART 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an ANEMIA 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2500 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Aatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 ☐ Could not be 3 T Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 🔁 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D. 10 20 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 3 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year HERBERT LEVY 1045 PM JANUARY 2004 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE CITY JOHNS HOPKINS BAYVIEW BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 6. Sex 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 1**X** M 2□ F Director 216-24-3458 MAY 28,1929 MD Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f shoy other traumatic event, the Medical Examiner must be notified at ¥XYes 2 □ No Directo MD BALTIMORE DUNDALK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a 112 EAST AVENUE USA Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ont: If item 27 is marked other than "natural", or ite Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2√√2 No Specify: 3 ☐ Widowed 4 ☑ Divorced BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 ENGINEER BETHLEHEM STEEL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be SMILEY LEVY CLEO MINTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHELDON LEVY/SON 3122 OAKFIELD AVE. BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Importent: If eny injury or once. Metro Crematory 01-12-04 Balto, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. agnes 1701-31 LAURENS ST. BALTIMORE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ROSTATE CANCER. /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for as a oursequence of). The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68750 Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Division of Vital 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Unpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No funeral dir Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of After 28c, Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause s) and manner as stated.
2 Medical Examinities: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES JANUARY 30. Name and ad of person who completed cause of death (Item 23a) (Type, Print) EASTERN AVE BUTIMORE SRIDHARAN 4940 ANIRUDH 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 1 3 2004 > Sener

DHMH 17 Rev 1/2001

Registrar

		For State Registrar	State	of Marylan		artment tificate			nd Me		giene		2 D 9	0.5.0
第 。第		Decedent's Name (First, Middle	, Last)						- :	2. Date of Dea			ear	3. Time of Death
Physic /Med		EULA	М.	LAII						JANUAR	Y 09	200	4	5:00 P M
Exami		4a. Facility Name (If not institution MILLENNIUM HEA	_	umber)		4b. City, To GLEN			Death			County of		EI OO
Funera	2004	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1	Year I	f Under 2		B. Date of Birth	7			EL CO. ace (State or Foreign ry)
Director		244-14-1106	1□M 2 X F	96	Yrs.	Months	Days	Hours	Min.	(Month, Day Dec. 5				yy Virginia
land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation							10	d. Inside City Limits
Mary a-f sh	tor	Maryland	N/A	Ba	ltimo	re								1XYes 2□No
or 28	Direc	10e. Street and Number	_			10f. Zip C					10g. Citiz		at Count	ry?
eath w	erai	818 Watervie		cedent Ever in U.	S 13 1	Was Deceder		2122		ity Yes or No-		S A 4. Race -	America	in Indian
If E, INIAL YIATLA Z.I.D-UUDO s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Hems 23a or 28a-f show other traumatic event, the Medical Explanation must be rediffed at	by Funeral Director	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorced	Armed F	orces? 2 No live		f Yes, specifi		Mexican, Specify:	Puerto A	ify Yes or No- ican, etc.)			White, e	tc.
72 hou		15. Decedent (Specify only highes	's Education t grade completed	')	(Give	dent's Usual (done dur	on ring most	of working	,	16b. Kin	d of Busi	ness/Ind	ustry
within ne.	Completed	Elementary/Secondary (0-12)	College	(1-4or 5+)	life. i	DO NOT use	retired)				0	II		
filed v Hygie other t		17. Father's Name (First, Middle,	Last)		Но	<u>nemak</u>		8. Mother	's Name ((First, Middle,	Own Maiden S		1e	
riario uld be fil Aental H rkad oth tic even	To Be	DOC MESS	EY					MIN	NIE	ELIZ	ABE'	ГН	RAM	ISEY
2 should land Meni	1	19a. Informant's Name/Relationsl		`	1					Route Numbe	_			
1 and 1 Health Health 27 other tr		BRADY A. LAI	L (SON	20b. P	face of Dispo	sition (Name	of	w Dr	ive,		20c. Loc			21226 vn, State
DEMILIMORE, permit. Pages 1 a Department of Heis Important: If item any injury or othe		1 Burial 2 Cremation 4 Donation 5 Other (S	pecify)	BA State	emetery, crer YVIEW	CREM	ATOI				BAL	ГІМС	RE,	Md.
Dermit Depar Impor any in		21. Signature of Fune al Service	Licensee		M ²	CCULL 204 M	Y-P(ount	OLYN tain	IAK Roa	FUNER	AL	HOME ena,	P. Md.	A 21122
Physician /Medical Examiner		23a. P. Enter the disease, or ock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	only one cause on	o (or as a conseq	Capari	er the mode	of dying,	such as co Hich	ardiac or	respiratory ari	rest,		1	Approximate Interval Between Onset and Death
oerificate be executed certificate be executed thing physician and use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	o (or as a conseq	uence of):		1 10							
U. DOX OX the death certifica the attending ph ched for use as th	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	1 Live	utcome of pregna birth 2 Feta gnant at time of d nown	Ideath 3□	Ectopic preg Other (spec					23	3d. Date of Month		y Day Year
law requires that the death as been signed by the atter 2 should be detached for u.	by P	Part II. Other significant condition	ens contributing to	death but not res	ulting in the u	nderlying cau	ise given	in Part I.			bacco us		ute to the	e cause of death?
age he	ompieted	Pulmay	emboli	am						24a. Was a autop: perfor	med?	prid dea	r to com th?	sy findings available pletion of cause of
VITAL ician: T certificat ector, pa	Be C	25. Was case referred to medical examiner?					2	6. Place	of Death	1 □ Yes (Check only or	2 No ne)		1100	70.0
OI V Physic rthis ce ral dire	2	1 ☐ Yes 2 📉 No			ER/Outpatier		1	4 Delvuis		e 5 Resid				
ding F h. After funera	tlon:	27. Manner of Death 1 ☑ Natural 5 ☐ Pendin 1 ☑ Accident investig	g (Mo	e of Injury onth, Day Year)	28b. Time of Injury	M 280	Unjury a Work?	t s 2 □N		3d. Describe h	ow injury	occurred		
OIVISION or Attending after death. Director: Afte	ertification:	2 Accident investig 3 Suicide 6 Could r 4 Homicide determ	not be 28e. Plac	ce of Injury - At ho ding, etc. (Specify						3f. Location (S City or Tow		Number	or Rumai	Route Number,
LIVISION OF VITAL To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, I	edical Co		g Physician: To the											
To the within To the Co the comple	Mec	29b. Signature and title of certifier					License n				29d. Date			
		30. Name and address of person	Mus			1)-40	1520	l	-	Jonas	my 1	12,20	404
N		30. Name and address of person	who completed cal	use of death (Iten	1 23a) (Type,	Print) 32	5 H	DIPC-	CAR !	DRIVE	210	161	208	
S Regis	tate trar	31. Date filed (Month, Day, Year)	3 2004	Registrar's Signa	iture	Cart S	1.							

		For State Amend Item//18per Registrar 1. Decedent's Name (First, Middle, Last)	FHG827 1/13	3/04 EW Ce	rtificate	e of L	Death		2. Date of De	ath	um tur eg i	3. Time of Death
Physicia		RAYMOND J. McDON	AID						JANUARY	4, 20	04 Yea	3:00A M
/Medic Examin	1 4	4a. Facility Name (If not institution, give s	treet and number)				Location o	f Death		4c.	County of De	oath COMERY
Funeral		SHADY GROVE HOSP 5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday)	If Under		If Under 2	24 Hrs. Min.	8. Date of Bir (Month, Da	th V Year)		Birthplece (State or Foreign Country)
Director		5/8-34-/634	M 2□F	74 Yrs.	Months	Days	riours	Will I	5/18/19	29	WA	SHINGTON, DC
yland		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation							10d. Inside City Limits
with the Maryland or 28a-1 ahow	ctor	WV BERKELE	Υ	MAI	RTINSE					10 000	1346.4	1 Yes 2XXVo
with the	Die	10e. Street and Number 62 RUMSEY TERRACE			10f. Zip	5401				US	zen of What	Country
er death with the Marylan Items 23e or 28a-f show ner mast be notified at	Funeral Director		2. Was Decedent E Armed Forces?	Ever in U.S. 13.	Was Deced	lent of Hi	spanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)			merican Indian, hite, etc.
8	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ N If Yes, Give Year or Dates:	° 1951– 1953	1 ☐ Yes 2		Specify:				Specify:	WHITE
_ 8	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5-	(Give	dent's Usua kind of wor DO NOT us ISHED	rk done d	lurina most	of workii	ng		nd of Busines	
othe	Be Co	17. Father's Name (First, Middle, Last)					18. Mothe		(First, Middle			
marked	10	LEO W. McDONALD	المتاما	10h 14cili	Addrsss	(Street)			JAUMBAC			
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		19a. Informant's Name/Relationship (Ty) MARY JO BELL McDONALI	_						RTINSBU			
Pages 1 and 3 ment of Health ant: If item 27 ury or other tr		20a. Method of Disposition 1 X Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)		20b. Place of Dispo cemetery, cre PROVIDENCE	osition (Name matory or of CEMET	ne of ther plac ERY	θ) J	IANUAR	POOL	HED	GESVII	or Town, State _LE, WV
permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service License	Beaun	2 [2. Name and BROWN F	d Addres UNERA	s of Facility L HOME	, P.C	BOX 82 MAR	21, 32 ETINSB	7 W. KI	NG ST., 25402
*) 10		23a. Part1. Enter the disease, or compli- shock, or heart failure. List only or	cations that caused e cause on each lin	the death. Do not en	ter the mode	e of dyin	g, such as	cardiac o	or respiratory a	rrest,		Approximate Interval Between Onset and Death
nysician /Medical		Immediate Cause (Final disease or condition resulting in death)	-	a consequence of):	6,000	Ž(Z						
xaminer			`	LE TESTICALON	Air							
sit.	iner	Sequentially list conditions, if any, leading to immediate rause. First Indenting.	Due to (or as a	a consequence of):								
sician and burial-transit	Examin	that initiated events resulting in death) Last	Due to (or as a	a consequence of):								
2 2 9	cai											
ing fair equites that he observed to have been signed by the attending phy bage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 ☐ Fetal death 3	⊒Ectopic pre					2	23d. Date of o Month	delivery Day Year
in signed by	by	Part II. Other significant conditions con	tributing to death bu	ut not resulting in the u	inderlying ca	ause give	en in Part I.			obacco u Yes 2[to the cause of death? Probably 4 □Unknown
	Completed								24a. Was auto perfo 1 \(\text{Yes}		24b. Were prior to death	
Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital: 🔏			Othe	25		(Check only			
this ral din	n: To	27. Manner of Death	28a. Date of Injur (Month, Day			8c. Injury Work	4 140		me 5 Resi 28d. Describe			ресіту)
after death. Director: After in by the funer	Certification:	1. Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Inju	ury - At home, farm, st	М	10	Yes 2 □ 1		28f. Location (City or To			Rural Route Number,
To the Hospital of At within 24 hours after To the Funeral Direct completely filled in by	I Cert	4 Homicide 29a. Certifier 12 Certifying Physics	building, etc	of my knowledge, dea	h occurred	at the tim	ne, date an	d place, a	and due to the	cause(s)	and manner	as stated.
n 24 h he Fur pletely	Medical	(Check only 2 Medical Examination)	on the basis of and manner sta	examination and/or in	vestigation,	, in my o _l	pinion, deal	th occurr	ed at the time,	date and	I place, and d	ue to the cause(s)
To the within 2. To the f	2	29b. Signature and title of certifier	Mu	J			9051	28	0		e signed (Mo	2004
10		30. Name and address of person who co	DADGAR,	eath (Item 23a) (Type 1219 EXEC	, Print) JTIVE	PAR	K TERI	RACE	, GERMA	NTOW	N, MD	20874
Sta		31. Date filed (Month, Day, Year)		ar's Signature	M ~							
Registr	ar 001	JAN 1 3 2004	Heren	D. 1900								

ORIGINAL

			For State Registrar	State of M	laryland i	-	artmen rtificat			ınd M		giene Rog. No.	200	4 6 3	era uz ua Lu-	- 1 T
			Decedent's Name (First, Middle, La								2. Date of Dea		Yea		3. Time of Deat	h
	Physicia /Medic		SANDRA	1	E.		1000	RE			JANNAF				4:131	4м
7	Examin		4a. Fecility Name (If not institution, gi	ve street and number))		4b. City,	Town, or	Location o	f Death		4c.	County of De	ath		
			Bon Secours Ho				Balt			04 Usa						
	Funeral			Sex 7. Ag 1 ☐ M 2 💢 F	ge (In yrs. last	birthday) Yrs.	If Under Months	Days	If Under a	Min.	8. Date of Birt (Month, Da	h y, Year)	9. 8	Country	•	eign
	Director		251-11-2819 Usual Residence of Decedent		39						09	6	4	S(
	land ow		10a. State 10b. County		10c. City, T	own or Lo	cation		-					10d	. Inside City Lin	nits
:	Mary Firsh	ţ	MD NA		Bal	time	ore								Y∏Yes 2□	No
	7.28g	Director	10e. Street and Number				10f. Zip	Code				10g. Citiz	en of What	Country	1?	
	23a C	aiD	37 North Gorma	an Ave				212	223			U	.S.A.			
	ems ems	Funerai	11. Marital Status	12. Was Decedent Armed Forces	?	13.	Was Deced f Yes, spec	lent of H cify Cuba	ispanic Origin, Mexican	gin? (Spe , Puerto l	cify Yes or No Rican, etc.)	- 1	4. Race - Ar Black, W			
36	s afte	by Fi	1 ☐ Never Married 2 ☑ Married	1 □ Yes 2√□ If Yes, Give Year or Dates:	K ₁₀		1 ☐ Yes	2 X No	Specify:				Specify:	- 1	-1-	
2-003e	within 72 hours after death with the Maryland ene. Than "natural", or llems 23a or 28a-f show the Modical Examiner must be notified at	효	3 Widowed 4 Divorced			6a Dece	dent's Usua	al Occup	ation			16b Kir	nd of Busines		ack	
2	in 72	Completed	(Specify only highest g	rade completed)		(Give	kind of wo	rk done i	during most	of workii	ng		e Tou		,	
775	iene.	E	Elementary/Secondary (0-12) 12th grade	College (1-4or		ort	rait	Cor	sult	ant		Pho	togra	phy	Y	
ਰੂ	illed Hygid other	Be C	17. Father's Name (First, Middle, Las		· •						(First, Middle,	Maiden	Sumame)			
<u>a</u>	ould be Mental arked o	To B	Charlie Scipio						Bert	:ha	Dixon			_		
듄 .	permit Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparmit of Health and Mental Hygiene. Deparment of Health and Mental Hygiene. Beginner if the 21 is marked other than "natural", or liems 23a or 28a-f show any injury or other traumatic event, it is Macilian Examinar must be notified at once.		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address	(Street	and Numbe	r or Rura	Route Numbe	er, City or	Town, State	, Zip C	ode)	
	and 2 Balth n 27 I		Bertha Samuel	-Mother		37	Nort	h Go	orman		e, Ba]				21223	
o ·	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	Removal from State	9 1		sition (Name				ate		cation - City			
<u>Ē</u>	Pages ment of I ant: If its ury or o		`4 □ Donation 5 □ Other (Spec	ify)	Metr						13/04	Ba	ltimo	re	Md	
ag E	permit Depar Import any in once.		21. Signature of Funeral Service Lice	ense		M	arch	F F	S of Facility	št						
_	<u></u>		- unu	Die	Ce						Balti		e Md	-	1215	
			23a. Part1. Enter the disease, or construct, or heart dilure. List on	nplications that cause y one cause on each l	ine.	Do not en	er the mod	le of dyin	g, such as	cardiac o	r respiratory ar	rest,		15	pproximate iterval Between inset and Death))
7 1	nysician	7	Immediate Cause (Final disease or condition resulting in death)	a. Bl	14丁ピ	IZA	2	PX	JUE	170	NIA			1	DAY	
	/Medical Examiner		resulting in dealiny	Due to (or as	s a consequen	ice of):			13			e	1		V	J
		_	Saquentially list conditions, if any, leading to immediate		AN IN		LNUI	DEA	=161,	ENZ	-y VII	2 11:	5	7-	2 /23	4
$\overline{}$	red	Ë	cause. Enter Underlying Cause (Disease or injury	200 (0 (0. 0.												
	al-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or as	s a consequen	ice of):								1		
8760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	cai		d.												
89	ifficati g phy as the	Physician/Medicai		<u> </u>										10		
ŏ	n cert	N.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e of pregnancy 2 Fetal de		∃Ectopic pr	ednancy				2	3d. Date of o)
 	deatl	icia	in the past 12 months? 1 □ Yes 2 □ No		at time of deat		Other (sp						Month	Da	ay Year	
P.O. Box	that the death certific ed by the attending p detached for use as	hys	9 🗆 Unknown								T					
S,	res th igned be de	by	Part II. Other significant conditions					ause giv	en in Part I.						cause of death?	
פֿי	w requir been si should I	ted	MALN	0174)	131261	131					יטי	res 2L]No 3 □	Probab	ly 4 Dounkno	JWII
ပ္	nelawr hasbe ge 2sh	pie	MALN	UTRITIO	ON						24a. Was autop	SV	24b. Were prior t	autops o comp	y findings availa letion of cause	able of
<u> </u>	The tate h page	Completed	ANAC	1114							perro 1 ☐ Yes	rmed? 2 X No	death 1 ☐ Y	? es 2l	□No	
/ita	cian: ertific ector,	Be	25. Was case referred to medical examiner?	Hospital:				Oth		of Death	(Check only o	ne)				
Division of Vital Records,	Physi this c al dir	2	1 ☐ Yes 2 🕱 No 27. Manner of Death	Hospital: 1 /2 npat 28a. Date of Inj		Outpatier b. Time o	nt 3 DC	OA Oth	4 140	-	ne 5 🗀 Resid			oecify)		
n c	fing f	ion	1 Natural 5 ☐ Pending	(Month, D	ay Year)	Injury	M	Wor	k? Yes 2 □ I		ou. Describe i	iow injury	00001190			
<u>is</u>	Attending or death. ector: Attel by the fune	icat	3 Suicide 6 Could not	be 300 Place of Ir	niury - At home	e. farm. st		7-7-7			28f. Location (S	Street and	l Number or	Rural P	Route Number,	
<u>≤</u>	after Direc	Certification:	4 ☐ Homicide determine	building, e	etc. (Specify)	, ,		,,			City or Tov	vn, State)				
_	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier 121 Certifying F	Physicien: To the bes	st of my knowle	edge, deat	h occurred	at the tin	ne, date an	d place, a	and due to the	cause(s)	and manner	as state	ed.	
	te Ho	edicai		eminer: On the basis and manner s												
	To the within To the Comp	Me	29b. Signature and title of certifier	2010	\mathcal{I}		290	c. Licens	e number			29d. Date	signed (Mo	nth, Da	y, Year)	
	7) L	DAIN	1	WD		D	233	00		JANU	ARY	07	200	4
	5		30. Name and address of person wh	o completed cause of	death (Item 23	3a) (Type,	Print) j	300	1 32	cor	123 h	031				***
	/		OUDHIR, D	, INTE.	L.	~20	00 W	, 1	542	50 5	1 13	92.T	0 17.	0,	2122	<u> </u>
	Sta Regist		29b. Signature and title of certifier 30. Name and address of person wh \$UDHIP D 31. Date filed (Month, Day, Year) JAN 1 3 200)4	J Julianur	600	مستنية									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day 2004 Year Jan Month **Physician** 9, Helen. Ma1m 12:20pм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Clinton MD Prince Georges If Under 1 Year If Under 24 Hrs.
Months Days Hours Min 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🕱 F 165-07-1044 89 Vrs Director September 21, 1914 PZ Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State other than "natural", or items 23s or 28s-f show yent, the Wedical Examiner must be notified at 1 Yes 2 No MD Charles Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1002 Peach Court 20601 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white à 3√2 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 10 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental Edward Willmer Kathryn McLauchlin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia W. Viets / Daughter 1002 Peach Court Waldorf, MD 20601 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, Stete crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 Removal from State permit. Page Department o Important: If any injury or once. 5 Holy Cross Jan. 15, 2004 Yeadon, * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 21. Signature of Euneral Service Licensee Victor P. Doda, Jr. 1501 East Fort Avenue, Baltimore MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed physician at s the burial-t Due to (or as a consequence of): Box 68760 Physician/Medicai 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 2 No 1 Tyes 2 \(\text{No} 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 1-Natural 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number. City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours after To the Funeral Dire To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29b. Signature and le of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANNETT GONSSIVES, 7503 Clinton MD 20735 Shratts 31. Date filed (Month, Days) 13 200432. Register's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** bruan 2004 Moore nnie /Medical 4b. City, Town, or Location of Death 4c. County of De 4a. Fecility Name (If not institution, give street and number) Examiner Genera 4 ranglan 7. Age (In yrs. last birthdey) Himore
Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Ye 9. Birthplece (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 ☐ M 2 🖫 F 58 214-56-0809 North Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
importent: if item 27 is marked other than "naturel", or items 23a or 28a-f ehow any injury or other traumatic event, the Wedical Exerciting must be coefficial at once. 10a. State 10b. County 1 SYes 2 No Baltimore Director 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number 1.S. A 1603 21211 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify:13/ack Specify: δ 3 Widowed 4 Spivorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) tousekee ping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Jones ္ eir be ouid 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route 20b. Place of Disposition (Name of cometery, crematory or other c Shantell a MOOI Baltimore, 20c. Location - City or Town, Stete 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) (em Carlon C. Doug 21. Signature of Funeral Service Licensee 1 Service Mc Cullot. War 1701 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 11050 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner executed for use as the burial-transit been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 The law requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 4 Donknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has page 2 1 Yes 2 No or Attending Physiclen: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification; To 27. Manner of Death 1 DNatural 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending Injury 1 Tes 2 No death. investigation 2 Accident within 24 hours after death To the Funeral Director: / completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 | Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a, Certifier (Check only one) 29b. Signature and title of pritifier 29c. License number 29d. Date signed (Month, Day, Year) 0 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ed Ka Mary 10 32. Registrati Signature 31. Date filed (Month, Day, Yeer)

DHMH 17 Rev 1/2001

State

Registrar

2004

		1 - State Registrar 1. Decedent's Name (First, Middle, Las	it) .	partment of Health and Mertificate of Death	2. Date of Death	No	3. Time of Death
Physic		JOHN W	1, Mca	LADE	Month	7 7 700 4	1149 AM
/Medi Exami		4a. Fecility Name (If not institution, give		4b. City, Town, or Location of Death		4c. County of Death	
		NORTHWEST HOSI	ITAL	Randallstown			ore County
Funeral Director		213-03-8330	7. Age (In yrs. last birthda XM 2□F 91 Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Dey, Y. Oct. 06 1	912 Mary	place (State or Foreign Tand
how		Usual Residence of Decedent 10a. State 10b. County Md.	n/a 10c. City, Town or Balt	Location			10d. Inside City Limits 1 ☐ Yes 2 🛣 No
Ba-fa	Director		n/a Bart			0111 (1111 1 0	
23a or 2	al Dire	10e. Street and Number 600 Light Street	Apt. 925	10f. Zip Code 21230	109	U.S.A.	intry?
E Ja	Funeral	t 1. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	B. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
"natural", or items 23a or 28a-f show	þ	1 ☐ Never Married 2 🛣 Marned 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give X Year or Dates:	1 ☐ Yes 2 ሺ No Specify:		Specify: Whi	te
natur	etec	15. Decedent's Ed (Specify only highest gra	lucation 16a. De de completed) (G	edent's Usual Occupation ve kind of work done during most of work . DO NOT use retired)	king 16	6b. Kind of Business/In	nd ustry
	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	ental Technician		J.S. Navy	
4 4		17. Father's Name (First, Middle, Last)			ne (First, Middle, Ma	iden Sumame)	
D .	To Be	John W.	McQuade	Beulah		Whitten	
27 ls r trau		19a. Informant's Name/Relationship (Virginia McQuade		iling Address <i>(Street and Number or Ru</i> 00 Light Street Apt			
if item or other		20a. Method of Disposition 1 XBurial 2 Cremation 3	cemetery, c	position (Name of rematory or other place)		c. Location - City or T	
jury o		' 4 □ Donation 5 □ Other (Specif	Druid Ride	e Cemetery		Baltimore,	
Important: any injury once.		21. Signature of Juneral Service Licer	m00922	McCully-Polyniak 130 E. Fort Ave.	Funeral H Baltimore	Home P.A. e, Md. 212	30
7,8		23a. Part1. Em a the disease, or com shock thead feiting, that only	ications that caused the death. Do not one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest	t,	Approximate Interval Between
cian		Immediate Cause (Final disease or condition	a VENTRICULAR +	BRILLATION			Onset and Death HOULL
lical iner		resulting in death)	Due to (or as a consequence of):				
	ĕ	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence of):				
ransit	Examiner	that initiated events	c				
s the burial-transit		resulting in death) Last	Due to (or as a consequence of):				
for use as the b	dical		. d				
use a:	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy			23d. Date of deliv	/ery
hed for	Physician/Medi	in the past 12 months?		B □Ectopic pregnancy □ Other (specify)		Month	Day Year
ac		9 Unknown	ontributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
9	Completed by	4	LLATION		1 ☐ Yes	2□No 3□Pro	babiy 4 @Unknown
should t	plete				24a. Was an autopsy	24b. Were aut	opsy findings available
page 2	E O				performe	death?	2 No
director, page	Be (25. Was case referred to medical examiner?			th (Check only one)		
<u>∈</u> =	2	1 Yes 2 No	Hospital: 1 Inpatient 21 R/Outpat			ce 6 □Other (Spec	rfy)
IJer IJer	tlon:	27. Manner of Death Natural 5 Pending Accident investigatio	28a. Date of Injury 28b. Time (Month, Day Year) Injur		28d. Describe how	injury occurred	
completely filled in by the funer	Certification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined			28f. Location (Stree City or Town,	et and Number or Rui State)	ral Route Number,
completely filled i			ysician: To the best of my knowledge, de				
me ra	Medical	one)	niner: On the basis of examination and/or and manner stated.				
1 000	2	29b. Signature and title of certifi-	un 1/2 MID	29c. License number		d. Date signed (Month)	
		20 Name and addition of	completed cause of death (Item 23a) (Typ	e Print)	1	anuny,	
Q		LAWRENCE 1. School	GT MD 5401 BLD (P. Print) OURT ROAD BALTIM	our MAN	LYCAND	21133
		31. Date filed (Month, Day, Year)	32. Regis rar's Signature				

	1	For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of F rtificate of			lene	00501.
		1. Decedent's Name (First, Middle, Las	t)				2. Date of Deat Month	h Day Year	3. Time of Death
Physicia /Medica	_	ROSLYN V. MI	LLER					1,2004	2:16 PM
Examine	_	4a. Fecility Name (If not institution, give				r Location of Death		4c. County of Dec	
		417 N. BELNORD 5. Social Security Number 6. Se		je (In yrs. last birthday		TIMORE If Under 24 Hrs.	8. Date of Birth	N/	
Funeral Director			M 20F	44 Yrs.	Months Days	Hours Min.	(Month, Day,		rthplece (State or Foreign Country) RYLAND
		Usuel Residence of Decedent					AUG.20	, 1959 1111	KIBIND
ms 23a or 28a-1 show		MD . 10b. County		10c. City, Town or L BALTIM					10d. Inside City Limits
or 28a-1 shore	Director			DABITA					1 Yes 2 No
De D		10e. Street and Number 417 N. BELNORD	ASTENITE		10f. Zip Code	224	1	0g. Citizen of What C	Country?
單	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S. 13			pecify Yes or No-	U.S.A.	encan Indian
event, the Medical Examiner or	Fun	1 ☐ Never Married 2 ☑ Married	Armed Forces?			lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black, Wh	ite, etc.
9	þ	3 Widowed 4 Divorced	1 ☐ Yes 2√ If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify:BL	ACK
4	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Dece	dent's Usual Occup	ation during most of work	kina	16b. Kind of Busines	s/Industry
4	nple	Elementary/Secondary (0-12)	College (1-4or	5+) /ife.	DO NOT use retired	during most of work d)			
1		9TH 17. Father's Name (First, Middle, Last)		DI	ETARY	10 Mothada Nom	e (First, Middle, M	NURSING	HOME
>	Be		KED						
Table	ို	COLEMAN LEE BA 19a. Informant's Name/Relationship (7)		19b Mail	ng Address (Street		S CLARI	K.E. City or Town, State,	Zin Code)
other traumatic event, the M		GERHONDA DIGGS						D, MD. 21	
100		20a. Method of Disposition		20b. Place of Disp	osition (Name of matory or other place	Conclusion regulator a security of		20c. Location - City o	
once.		Murial 2 ☐ Cremation 3 ☐ 14 ☐ Denation 5 ☐ Other (Specify		MT.ZION		,	2004	BALTIMOR	E.MD.
9		21. Storature of Funeral Service Licen	see / //					RAL HOME	5,115
once		Dernadine	71. AC		412 E. I	PRESTON	ST. BAI		21213
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that cause one cause on each I	d the with. Do not en					Approximate Interval Between
ian		Immediate Cause (Final disease or condition			Hodel	in Dis	(das		Onset and Death 4 Moulti
cal ner		resulting in death)	Due to (or as	a consequence of):	0				1
	_	Sequentially list conditions,	b. — Due to /or as	a consequence of):					
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence or).					
	xar	that initiated events resulting in death) Last	Due to (or as	a consequence of):					
	cal	(d						
	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		□Ectopic pregnancy	,		23d. Date of de	
	sicis	in the past 12 months? 1 ☐ Yes 2 No	4□Pregnant a 9□ Unknown		Other (specify)			Month	Day Year
	Phy	9 Unknown					20a Distant		to the course of death?
	by	Part II. Other significant conditions of	ontributing to death i	out not resulting in the t	inderlying cause giv	en in Parti.			to the cause of death? Probably 4 Unknown
	eted	AIDS					:		
1	Completed						24a. Was ai autops perforn	y 24b. Were a prior to	utopsy findings available completion of cause of
		**					1 ☐ Yes	No 1 □ Ye	s 250 No
E S DE S C C C C C C C C C C C C C C C C C C	o Be	25. Was case referred to medical examiner?	Hospital:	2/JEB/0	at 30 DOA Oth	0.011/200-1-00121-0-1	th (Check only on		
D as	\vdash	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Inj. (Month, Da	ent 2 ER/Outpatie	IN SELDON	4 Li Nuising no		nce 6 Other (Spewinjury occurred	ecity)
ounj e	tior	1 Natural 5 Pending 2 Accident investigation		ay Yeer) Injury		k? Yes 2 □No			
ri da	Certification:	3 Suicide 6 Could not be determined	280. Place of III	jury - At home, farm, st	reet, factory, office		28f. Location (Sti City or Town	reet and Number or F	Tural Route Number,
	Cert	4 El Florincido	Duilding, 6	ic. (opacity)			Only or round	, State)	
				of my knowledge, dea of examination and/or it					
	Medical	one)	and manner s						``
Diagram of the control of the contro	-	29b. Signature and title of certifier			29c. Licens	e number		d. Date signed (Mon	
	Σ	N N			-				
complete	2	> Dwilliam P	senedich.	m	Do	\$3583		1/11/20	04
ompletely filled in by the funeral director, page	N	30. Name and address of person who	completed cause of	death (Item 23a) (Type	Print)	1 583	A 15	1/11/200	64

			1 - For State UNPEND ITEM 23a	State of &27 PER ME	Maryland G827 1/2	1 / Depa 8/0⁄ਦੂ[rtment <i>tificate</i>	of He	alth ar eath	nd Me	ntal Hyg	iene	LUOL,	ivij	
Ç.			Decedent's Name (First, Middle, La								. Date of Dea	th	1,22	3. Time of Death	
	Physici /Medi		Nancy L.	Norris							January	Day 7,	2004	8:09 P M	
	Examir		4a. Facility Name (If not institution, give		er)		4b. City, To			Death			ounty of Deeth		
-	<u>.</u>		Saint MAry's Hosp				Leona		OWD If Under 24	Hen I a	5		MAry's		
	Funeral Director			Sex 7. 1□M 2√7 F	Age (In yrs. Ia	Yrs.				Min.	Date of Birth (Month, Day UNE 29	Year) 196	Cour	place (State or Foreign ntry) yland	
	land		10a. State 10b. County		10c. City,	Town or Lo	cation						1	IOd. Inside City Limits	
	Mary if sh	to	Maryland Saint	Marys	Lexi	ngton	Park							1 ☐ Yes 2X No	
	n the	rec	10e. Street and Number	-			10f. Zip Co	ode			1	0g. Citize	n of What Cour	ntry?	
	ih wit	ai	45818 Lord Balti	more Way			206.	53				USA			
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatile and Menial Hygiene. Department of Heatile and Menial Hygiene. The Medical Fractile and Standard of the than "natural", or flams 23e or 28e-f show sny injury or other traumatic event, Le Medical Eractile at must be notified at ances.	by Funeral Director	11. Marital Status 1 □XNever Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 Tes 2 If Yes, Give Year or Date	es? DXNo	11	Vas Deceden Yes, specify	Cuban,	anic Origin Mexican, F Specify:	? (Specif Puerto Ric	ty Yes or No- can, etc.)	ŀ	Race - Amend Black, White, pecify:		
3	2 hou	ed	15. Decedent's E			16a. Deced	ent's Usual (Occupation	on			16b. Kind	of Business/Inc		
3	hin 72 In "In Medii	Completed	(Specify only highest gri	ade completed) College (1-4)	or 5+)	(Give I	kind of work of OO NOT use	done dur retired)	ring most of	f working				,	
	giene giene Pr tha	E O	12	Conlege (1-4	51 5+7	Desk	Clerk					Hote	el / Gue	est Servic	
Danimole, mai yiania z iz 13-000	al Hy d oth	Be (17. Father's Name (First, Middle, Last)				18	8. Mother's	Name (I	First, Middle, I	Maiden Su	ımame)		
	should the market was	၉	Leo Paul Norris										ıllough		
	12 sh h and h sm rsm rsum		19a. Informant's Name/Relationship (own, State, Zip		
5	1 and Health em 27 ther tr		Juanita L. Lawre	nce/Siste			Maripo Sition (Name		Avenu	e Dat			Palms,		
	Pages nent of int: If it iry or o		1 Burial 2 Cremation 3		te cer	metery, crem	ematory or other	r place)	_ 1						
	iit. Paritme artme ortani injury		* 4 □ Donation 5 □ Other (Special Service Lice)		riet.				- 1				imore,	MD	
i	permit. Departr Imports sny inj		21. Signature of Funeral Service Lice Edward A	Gregorchi	.k	2	remat 199 Fre	ion . eder:	Socie ick R	ty o oad	f MD, Bal	Inc. timor	e, MD	21228	
			23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line. Approximate Interval Between												
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)		NSIVE ATT as a conseque		EROTIC (CARDIO	OVASCUI	LAR 1	DISEASE			Onset and Death	
ĺ	i er	r e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying								-				
	uted J ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events												
î	icate be executed physician and sthe burial-transit	Exa	resulting in death) Last	Due to (or	as a conseque	ence of):									
	ite be iysicia iysicia iysicia	dicai	(_d											
	ng ph	Med	IF FEMALE:												
	that the death certificated by the attending placed by the attending placed for use as the	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 Sunknown		2 □ Fetal d tat time of dea	leath 3	Ectopic pregr Other (speci			-		23d	. Date of delive Month	ry Day Year	
5	The law requires that the site has been signed by the page 2 should be detached.	by Pt	Part II. Other significant conditions	contributing to deat	h but not result	ing in the un	derlying caus	se given i	in Part I.		23e. Did tob	acco use	contribute to th	e cause of death?	
	quires in signi	d b									1 🗆 Ye	s 2 🗆 N	lo 3 Proba	ably 4 🗆 Unknown	
	law requir as been si 2 should	Completed								}	24a. Was ar		4b. Were autor	sy findings available	
	The lavine lavine lavine lavine las	шо								-	autops perform	ned?	prior to con death?	npletion of cause of 2 No	
į	ysicien: The list certificate had director, page	BeC	25. Was case referred to medical					20	6. Place of	Death C	heck on one	No No	20105	2 NO	
	Physicien: this certificatal director.	ToE	examiner? 1 ☑Yes 2 ☐ No	Hospital: 1 Inpa	atient 2 El	R/Outpatient	3□ DOA	Other:	4 🗌 Nursir	ng Home	5 🗆 Reside	nce 6	Other (Specify)	
	Attending Pi	ation:	27. Manner of Death XX Natural 5 Pending 2 Accident Investigation		njury 2 Day Year)	8b. Time of Injury	28c.	Injury at Work? 1 Yes	s 2 □ No	280	I. Describe ho	w injury o	ccurred		
	of or Attending after death. I Director: After In by the funer	Certification;	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of	Injury - At hom etc. (Specify)	ne, farm, stre	et, factory, or	ffice		28f.	Location (Str City or Town	reet and N . State)	umber or Rural	Route Number,	
/	To the Hospitel or Attending Phymitin 24 hours atter death. To the Funerel Director: After the completely filled in by the funeral	Medical C	29a. Certifier (Check only one) 1 Certifying Pr 2 Medical Exam	nysician: To the be miner: On the basis and manner	s of examinatio	ledge, death on and/or invi	occurred at t estigation, in	he time, my opini	date and p ion, death o	lace, and	due to the ca at the time, da	use(s) and ite and pla	d manner as sta ice, and due to	ated. the cause(s)	
	ro the within 2 To the complet	Z	29b. Signature and title of certifier	A AR	1			icense ni			- 1		gned (Month, E		
	7		30. Name and address of person who	completed cause of	of death (Item 2	23a) (Tyne. P			-			سالاس	-1 0, 2		
1			ZABILLAH	ALI	(112)	, , , , , , , , , , , , , , , , , , , ,		Penn	Stre	et,	Baltim	ore,	Marylar	nd 21201	
	Sta	ite	31. Date filed (Month, Day, Year)	32 Regi	strar's Signatu	re							-		
	Registr	ar	IAN 1 3 200	14 Mesey	w St	A SO	A.								
HM	IH 17 Rev 1/2	001	WI III	2											

DHMH 17 Rev 1/2001

ORIGINAL

		1 - For State Registrar 1. Decedent's Name (First, Middle, Last	State of Mary		artmer rtifica					g. No.	004	3. Time of Death
Physici /Medi Examir	cal	Catherine 4a. Fecility Name (If not institution, give	C.	N	ichol		Location of		Month Jan	5 ^{Day} 4c. Count	2004 ty of Death	09:26 Р м
Funeral Director		Ridgeway Manor Nu 5. Social Security Number 024-07-3258 6. Se 10		yrs. last birthday 1 Yrs.		r 1 Year	If Under 24	4 Hrs. Min.	8. Date of Birth (Month, Day, Aug 13,		9. Birth	place (State or Foreign ntry) MA
the Maryland 28a-f ehow	rector	Usual Residence of Decedent 10a. State 10b. County MD Anne A		: City, Town or L Linthic	ım	p Code			10	Og. Citizen of		10d. Inside City Limits 1 ☐ Yes 2 X No
DERRITHOTE, INTERTIGING Z I Z I 3-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deportment of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23e or 28e-f show any injury or other treumatic event. The Medical Examinar must be notified at ance.	Completed by Funeral Director	412 Darlene Avenue 11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 📉 No	in U.S. 13.	Was Dece If Yes, spe	21090 Ident of Hi porty Cuba		n? (Spec Puerto R	ify Yes or No-	14. Ra Bla	U.S.	A • can Indian, etc.
Maryiand ZIZI3-UU30 Id 2 should be filed within 72 hours alt th and Mantal Hyglene. It's marked other then "natural", or treumatic event, the Medical Exam.	pieted by	3 Ni Widowed 4 □ Divorced 15. Decedent's Ed. (Specify only highest grace Elementary/Secondary (0·12)	If Yes, Give Year or Dates:	(Give	1 Yes dent's Usu kind of wo	al Occupa	furing most o	of working	9	16b. Kind of I		
Idina 6 14 Id be filed with ental Hygiene ked other the ic event, the	To Be Com	12 17. Father's Name (First, Middle, Last) Joseph Brousses		Нот	nemake	er		-	(First, Middle, M	faiden Suma	Home	
3, IVICITY I and 2 shou fealth and M im 27 is man	-	19a. Informant's Name/Relationship (T) Mr. Daniel Nicho	ls/son	19b. Mail 412 I)arle	ne Av	renue]	Lint	Route Number, hicum,	MD 21	090	
Desirimore, permit. Pages 1 av Department of Hea Important: If item any injury or othe		20a. Method of Disposition Daurial 2 Cremation 3	Removal from State	St. Mary	matory or o 7 S Co 2. Name a	other placemete emete	ry sof Facility	n 12 2004 Sin	gleton	Oc. Location Uxbrid Funera	ge, M	íA ne, P.A.
Physician /Medical		23a Part. Enter the disease, or comp shock, or heart failure. List only o himed ate Cause (Final disease or condition re juling in death)	ications that caused the cause on each line. Locations that caused the cause on each line. Due to (or as a cor	death. Do not en		de of dying		ardiac or	Glen Burrespiratory arre		MD 21	Approximate Interval Between Onset and Death S. C. W.
sate be executed by sician and the burial-transit	licai Examiner	Esquentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor	nsequence of):	3			0				9200
The law requires that the death certifica to has been signed by the attending phage 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pri 1 □ Live birth 2 □ i 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	⊒Ectopic p ⊒ Other (s)						ate of delivionth	ery Day Year
w requires that been signed b	ed by Pł	Part II. Other significant conditions co		-	underlying (cause give	en in Part I.		23e. Did tob			he cause of death? pably 4 Unknown
	Completed	Dementa								ed? XNo	prior to co death?	ppsy findings available mpletion of cause of 2 No
ding Phys	ition: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 / Accident investigation	lospital: 1 Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatie 28b. Time o Injury		28c. Injury Work	or: 4 Nursi	ing Home	Check only one By Sesider Check only one	nce 6 Ot		'y)
To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (Sc	ecify)					City or Town,	State)		al Route Number,
To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in I	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medicel Exami	sician: To the best of my ner: On the basis of exar and manner stated.	nination and/or in	ivestigation 29	n, in my op c. License	number	occurred	at the time, da	te and place,	, and due to	o the cause(s) Day, Year)
In		30. Name and address of person who of	GAMAN GALLAND	(Item 23a) (Type	Print)	Dá	7541 Bal	time	ary IV	Janva 10-2	ng 9 122 -	1
Sta Regist		31. Date filed (Month. Day, Year)	32. Registrar's 2034	gnature	30	hand	8,					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Jan. **Physician** Marie Madeline Otto 2004 4:10 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 214 Homevale Rd. Reisterstown Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. June 2, 1943 Birthplece (State or Foreign Country)
 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 KF 60 213-42-3303 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Madical Examiner must be notified at Maryland Baltimore 1 Yes 2 No Director Reisterstown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ō 214 Homevale Rd. 21136 U.S.A. "natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene.
7 is markad other than "r Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Beautician permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If item 27 is marked oth any jury or other traumatic event size. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Donald Brewer Marie M. Raver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 214 Homevale Rd. Reisterstown, Md. 21136 Glenn Otto - husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Mem. Gardens Jan. 12,2004 Finksburg, Md. 22 Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, Md. 21117 21. Signature of Funeral Service Licensee . Lath Ellos 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CHOLANGIOCARCINOMA **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner and the death certificate be execu Box 68760,7 Due to (or as a consequence of): Completed by Physiclan/Medical as the attending f IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ Yo 23d. Date of delivery 3 Ectopic pregnancy Month Voor Day 5 Other (specify) 4 Pregnant at time of death signed by the a d be detached t P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 🗌 Yes 2 No 3 Probably 4 □Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 s has performed2 1 Yes 2 No certificate Division of Vital Director: After this certific in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient Medical Certification; To 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 | Homicide To the Hospitel o within 24 hours aft To the Funerel Di completely filled 1 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and le D 48234

O (Item 23a) (Type, Print)

2411 W. BELVERRIE AVEST 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A . STEVEN FLEISHER . 24(1 W. B 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear **Physician** Margaret J. Painter 0926 AM 10 2004 January /Medical 4a. Facility Name (If not institution, give street and number)
Union Memorial Hospital 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Nov. 27, 1 N/A Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 M XXF 214-20-9008 1925 Maryland Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c, City, Town or Location 10a. State itam 27 is marked other than "netural", or itams 23a or 28a-1 show other traumatic event, the Modical Examiner must be notified at ty Yes 2 □ No Maryland N/ABaltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1422 Berry Street 21211 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or item eny injury or other traumatic svent, the Michical Examinations. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Baltimore, Maryland 21215-0036 ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be (Everette Johnson Helen Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1422 Berry Street Baltimore, Maryland 21211 Lawrence Painter Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State 01/13/2004 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc. Henss 3631 Falls Road, Baltimore, Maryland 23a. Part1. Effer the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) one day **Physician** Myocardial Infarotion /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or it jusy that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires thet the death certificate be executed use as the burial-transi attending physicien and Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed res 2 certificate 1 Yes or Attending Physician: director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Dinpatient 2 ER/Outpatient 3 DOA this completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 2 Accident 5 Pending 1 Yes 2 No investigation within 24 hours after death. To the Funeral Director: A 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MDJanuary 10, 2004 AT2438946 D9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Catherine Meschler, Union Memorial Hospital; 201 EUniversity Parkway; Baltimore MD 21218 31. Date filed (Month, Day, Year) Registrar's Sgnature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day -Month **Physician** Judith G. Phillips anuary 6 2004 740A M /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Paltimore General Manilound If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb 20 1923 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours Months 1 ☐ M 2 🕅 F 80 227-24-7804 VA Director Usual Residence of Decedent 10a. State Md 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show or other traumatic event, the Medical Examiner must be notified at Carrol1 Sykesville 1 ☐ Yes 2 1 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5831 White Rock Road 0 21784 USA or Items 23a Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Tiggreices?

Iggreices?

If Yes, Give A

Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: White 3 ☐Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If tem 27 is marked other than "na any injury or other traumatic event the page." food service Elementary/Secondary (0-12) College (1-4or 5+) waitress 12 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name /First Middle Last William Dean Ida Kav Elam 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6521 Shenendoah Dr., Sykesville, Md 21784 Michael Phillips (son) 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 \$\overline{\Omega}\$ Burial 2 □ Cremation 3 □ Removal from State Marriottsville, Md Crest Lawn Memorial 4 □ Donation 5 □ Other (Specify) 1-9-04 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature/bf Funeral Service Licensee P.O. Box 195 Sykesville, Md 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Closed ead hour **Physician** /Medical CERTIFICATION I Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-transit EXAMINED. In ORKIN Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day ģ 4□Pregnant at time of death detached 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Wunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page. performed? 2 No 1 ☐ Yes 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending 1 ☐ Yes 2 No SUBJECT FELL DOWN STAIRS 3-2004 UNK death. 2 Accident investigation the Director 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by within 24 hours after To the Funeral Dire Home 5831 WHITEROCK ROAD, SYKESVILLE MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Morgan, MD 01/06/2004 Ayman 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 827 Linden Acc Ayman land 10 man Morgan 31. Date filed (Month, Day, Year) a. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 2004 1:00 p.M Wilda В. Patterson /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Balto Randallstown Future Care if Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 1 25 19 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Min. Months Days Hours 1 M XXF ′Va 87 1916 Director 213-26-6553 Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County in then "natural", or items 23a or 28a-f show the Medical Exercitives must be notified at 1X Yes 2 ☐ No Directo Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21215 3808 Reisterstown Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes Who Specify: Specify: þ Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) National Can Company Assembly Line 12th grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any jury or other traumatic event size. Be Phoebe Clarke Henry Patterson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ronnette Atkins-Grandddaughter 1011 Cameron Road, Baltimore Md 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Garrison Forest Vet. 1/20/04 Owings Mills, Md 21. Signature of Funeral Service License 22. Name and Address of Facility March F/H West Md 21215 4300 Wabash Avenue Balto. 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1+0/10 SCLETOSIS **Physician** 20 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed tension 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes ٩ this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manne of Death 28b. Time of 28c. Injury at Work? Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death Director: 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date signed (Month. Dav. Year) 29c. License number 29b. Signature and title of certifier D0020964 1/07/2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Jerome H. Ginsberg, M.D. 8630 Liberty Plaza Mall 32. Aggistrar's Signature 31. Date filed (Month Axi Year) 3 2004

Randallstown, MD

Please	ype or Print in Black Indelible Ink. Ensure All Copies Are L	_egı
	State of Maryland / Department of Health and Mental Hygiene	

		1 - State Registrar Certificate of Death Re 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2. Date of Death								Cr Est of	3. Time of Death
Physicia	an	1. Decedent's Name (First, Middle, La	Richard	1 T. F	alm	er		Month	Day	Yeer	
/Medic Examin		4a. Fecility Name (If not institution, gir	ve street and number)			4b. City, Town,	or Location of Dea	⊥ Janua th		2004 inty of Death	10:25 A
Examin	eı	St. Agnes Hospita	_			Baltimo	re				
Funeral			Sex 7. Age (In yrs. last b		If Under 1 Year Months Days			9; 1941	9. Birth	olace (State or Foreign
Director		219-30-4194	ILAM ZUP	62	Yrs.			Dec 2	9, 1941	IV	laryianu ——————
and		Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, To	wn or Loc	ation					10d. Inside City Limit
Mary -1 sh	tor	Maryland I	N/A			E	Baltimore				1 ☐ Yes 2 ☐ N
ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Heatth and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-1 show or other traumatic event, the Medical Examinar must be notified at	Funeral Director	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Cou	
23a c	rai	3155 Leeds Ave					21229				
er dea	nue	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	13. V	as Decedent of Yes, specify Cui	Hispanic Origin? (5 ban, Mexican, Puer	Specify Yes or N rto Rican, etc.)	o- 14. F	Race - Ameri Black, White,	
rs afte	y F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 X Yes 2 No If Yes, Give Year or Dates:	1960 1964	1	□Yes 2 No	Specify:		Spe	ecity:	Black
thou stura	Completed by	15. Decedent's E	ducation	1 7.7	a. Deced	ent's Usual Occu	upation		16b. Kind o	f Business/In	dustry
nin 72 na nin	plet	(Specify only highest gi	rade completed) College (1-4or 5+)		(Give I life. D	O NOT use retir	e during most of wo	orking		Baltimor	e City
giene giene er the	Com	12				Pol	ice Officer				
be filed tal Hygi d other	Be (17. Father's Name (First, Middle, Las	^{t)} H. Palmer				18. Mother's Na	me (First, Middle Ali	e, Maiden Sun ce V. Palr		
ould to	2					_			nber, City or Town, State, Zip Code)		
12 sho h and 7 Is mu traum		19a. Informant's Name/Relationship Brooke Hikelle Myers		19			et and Number of R le Bridge Roa			wn, State, Zip	Code)
1 and Healt em 2	1 4	20a. Method of Disposition		20b. Place	of Dispos	ition (Name of atory or other pl		Date	20c. Location	on - City or To	own, State
ages on of t: If it		1 Burial 2 □ Cremation 3 (_Hemoval from State				ace) is Cemetery	01/20/04		-	Maryland
permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		*4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice		Outrio							
Depa Impo any i		1 (60) GG 5-	7			Estep	ress of Facility Brothers Fundation	eral Home I Baltimore, N	од ИD 21217		
		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused th	e death. Do							Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	humste	050	10 1	athero	scleroh	1 card	NASON	rdsm	Onset and Death
/Medical		resulting in death)	a. Doe o (or as a c	consequence	e of):	500	00.00	(LIII)		CE CL	
Examiner		Sequentially list conditions.	b								
pe tis	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
tificate be executed ig physician and as the burial-transit	Examiner	that initiated events resulting in death) Last									
be execu sician and burial-tra	calE										
certificate Iding phys			d								
eath certificate be execu attending physician and for use as the burial-tra	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2		•b 2□	Ectopic pregnan			23d.	Date of delive	ery
D 0 D	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at tin			Other (specify)	-y			Month	Day Year
ac of	hys	9 Unknown						T			
res that igned to be det	by	Part II. Other significant conditions	contributing to death but	not resulting	in the un	derlying cause g	iven in Part I.				he cause of death? pably 4 Unknow
w requir been si should	ted	ourses m	en no					''	Yes 2 □ No	3 ☐ Prot	
62 63	nple							24a. Wa:		 b. Were auto prior to co death? 	psy findings availab mpletion of cause of
P ta od								1 Yes	2□No		2 No
Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				ther	ath (Check only			
Phys	7	1 ∑Xes 2 ☐ No 27. Manner of Death	1 ☐ Inpatient	280 ER/C	Outpatient . Time of	3 DOA	4 Nursing i	Home 5 Res	how injury oc	- ' '	y)
ding l	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Y	(ear)	Injury	W	ork? ⊒Yes 2 ⊒No		,-,		
Attending r death. octor: Afte	flca	3 Suicide 6 Could not	be 28e. Place of Injury		farm, stre	et, factory, office	,			mber or Rura	I Route Number,
or afte Dire	Certification:	4 Homicide	building, etc.	(Ѕреспу)				City or 10	own, State)		
Hospital Hospital Funeral			hysician: To the best of								
the Hillin 24 the Fi	Medical	one)	miner: On the basis of each manner state	d.	and/or my			uned at the time			
of all of the second	Σ	29b. Signature and title of ceditier	Q.	101			nse number		29d. Date sig		-
, (1)	1	1 dul	181 max	Jak	حبب		.M.E.		Januar	ry 10,	2004
11		30 Name and address of person who	completed cause of dea	th (Item 23a	(Type, F		n Street,	D-344		-	7 01001

Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

	الطأار			State of r	waryian		epartment o Certificate	of Death	o Mentai H	ygiene Reg. No.	2004	00562
	Physician	Decedent's Nam	V NI-W		1				2. Date of I	Dey	Year	3. Time of Death
	/Medical	Annie 4a Fecility Neme <i>(l</i>	Mae If not institution air		oebus		_	4b. City. Town.	or Location of Dea	m) 1	2004 ounty of Death	6,45 Am
	Examiner	Nort		mdel	Hos	57/5) w)	(5)m	Burn		nne	Brundel
	Funeral Director	5. Social Security N 212-34-37	1umber 6. 5		Age (In yrs. I	le <i>st birtho</i> 59 Yrs	Months Da		8. Date of E (Month, I 5-8-1	Birth Day, Year) 934	9. Birth Cou	nplace (State or Foreign untry) VA
and	ž ==	Usuel Residence of 10a. Stete	Decedent 10b. County		10c. City	, Town o	r Location					10d. Inside City Limits
Many	r 28a-f show notified at rector	MD	Anne Aru	ınde1	G	1en	Burnie					1 ☐ Yes 2 🙀 No
th the	or 28a-1 s be notified Director	10e. Street end Nur	mber				10f. Zip Cod			10g. Citize	n of What Cou	intry?
at w	23a math		mmer Road				210				USA	
020 urs after de	at, or items 23s Examinet must by Funeral	11. Maritel Status 1 □ Never Marri 3 ☒ Widowed	ied 2 Married 4 Divorced	12. Was Deceder Armed Force 1 Yes 25 If Yes, Give 4 Year or Date:	s? ₹No	S.	13. Was Decedent If Yes, specify (1 ☐ Yes 2🎇	of Hispenic Origin? Cuban, Mexican, Pu No <i>Specify:</i>	' (Specify Yes or N uerto Rican, etc.)		. Race - Amer Black, White pecify: W	
Maryland 21215-0020	ygiene. Ner than "natura It, the Medical I	Elementery/Seco	15. Decedent's E cify only highest gra andary (0-12)	ducation ade completed) College (1-4c	or 5+)			ccupation one during most of titred)	working		of Business/I	ndustry
D 2	Hygie ont, ir	17. Father's Neme	(First, Middle, Lest	")			Sales clo		Name (First, Middi	le, Maiden Su	ımame)	
/lan	Mental H arked oth artic even	Clayton	J. Ayers	3				Viv	ianne Ir	ene Ma	rtin	
Aar) 2 sho	is me	19a. Informant's Na						reet and Number or				p Code)
6 . 1 and 1 and	Health em 27 ther t	Mr. David		/ son	20b. Pl		4 Beach 1		dena MD		Z tion - City or T	own State
Baltimore, permit. Pagas 1 an	Department of Health and Mental Hygiene. Important: If Item 27 is merked other than "I any injury or other traumatic event, the Mes page. To Be Comple	1X Burial 2 l 4 □ Donetion	☐ Cremation 3 ☐ 5 ☐ Other (Specil		Che	1ten	ham Vete:		1/15/04	Waldo	orf, MI)
Ва	Depar impor any in pncs.	21. Signartire of Fu	neral Service Lice	Silles	M013	64		Ave SW,				
· Ne		23a. Part1. Enter the shock, or hear	ne disease, or com rt failure. List only	plications that caus one cause on each	ed the death line.	. Do not	enter the mode of	dying, such as card	fiac or respiratory	errest,		Approximate Interval Between Onset and Death
1	nysician Medical xaminer	Immediate Cause (disease or condition resulting in death)	Final n	a. Pn	en m	74'	から				1	Onset and Death
DE DE	niner			b. Cov	Due to (or	as a cor	rsequence of):	eart	fail	w ?		
68760, flicate ba axeou	physician and its the burial-transit edical Examiner	Sequentially list cor if eny, leading to im cause. Enter Unde Cause (Disease or that initiated events	nditions, imediate rhying injury	.Chr.	Die to (or	as a cor	obst ~	erits.	lmg	di	S& ESE	2
	O 0	resulting in death) L	ast	d	Due to (or	as a con	sequence of):					
Box Bath cer	attend of for us	Day II Othan almoit	la a má a san diata un a					-1 1- D1	ant Di	4		
, P.O.	ed by the datached y Physi	Part II. Other significance	2 & to	Sontributing to death	but not resu	25	e underlying cause	given in Pert I.		Yes 2 🗆 I		o the cause of death?
Division of Vital Records, P.O. Box or Attending Physician: The law requires that the death cer	this cartificate has been signed by the attending physician and all director, page 2 should be datached for use as the burial-transit: To Be Completed by Physician/Medical Examir								24a. Wa	s an autopsy formed?	a\	ere autopsy findings vailable prior to pmpletion of cause death?
- Re	page Com								40	Y69 27 N		□Yes 215 No
/ita	artifica ector, Be (25. Was case referrexaminer?	red to medical	Magnital. /					Death (Check only	one)		
of V	this crail dire	1 ☐ Yes 2 ☐		Hospital: 1 Sunpa		ER/Outpa 28b. Tim	TIENT 3L DOA		Home 5 ☐ Res 28d. Describe			5)
On	th. : After e fune	1 Natural 2 Accident	5 Pending investigation	(Month, E	ay Year)	Inju		njuryat Work? I∐Yes 2∐No	200. 2000120	Thow anjury of	ccarred	
Divisi	within 24 hours after death. To the Funeral Director: After this cartificate ha completely filled in by the funeral director, page Medical Certification: To Be Com	3 ☐ Suicide .4 ☐ Homicide	6 Could not be determined	200. Place of I	njury - At hor etc. (Specify,	me, farm,	street, factory, offi	се		(Street and Nown, Stete)	lumber or Run	al Route Number,
► Hospita	• Funera • F	29a. Certifier (Check only one)	15 Certifying Ph 2 Medical Exam	nysician: To the besinner: On the basis and manner:	of examinati	vledge, de ion and/o	eath occurred at the r investigation, in m	e time, date and pla ny opinion, death oc	ice, and due to the curred at the time	cause(s) and , date and pla	d manner as s ace, and due t	tated. o the cause(s)
, Š	To th comp	29b. Signature end	title of certifier	-, M	nD		29c. Lic	ense number		29d. Date si	igned (Month,	Day, Year)
	5	30. Name and addre	ess of person who	completed cause of	death (Item	23a) (Ty	pe, Print)	dr	(7)-	n Bi	r mi 4	, m) 2166
	State Registrar	31. Dete filed (Mont	JAN 13	2004 32. Ref	trer's Signat	ure	Roselis		/	and a second second second second second second second second second second second second second second second		-

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Richard 50 -7,2004 : 20 PM Ruth January Itnna /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Bultimole 1timore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Hours Min. Nov 201947 5. Social Security Number 9. Birthplace (State or Foreign Vauntry) 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 217 F 213-52-0040 56 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits item 27 is marked other then "naturel", or items 23a or 28a-f show other treumatic event, the Medical Exertainst must be notilised at Md Carroll Eldersburg 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21784 USA 6202 Frontier Court by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Md School for Elementary/Secondary (0-12) College (1-4or 5+) child care supervisor the Blind 12 should be fited who and Mental Hygie 7 is marked other ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Kennel Ruth Hansel ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important; if item 27 Is neny or other treum Nancy Zeleski (friend) 6202 Frontier Ct., Eldersburg, Md 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State

' 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md Moreland Memorial 1-9-04 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Daige Haught Herbert P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death fmmediate Cause (Finaf **Physician** 0 resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it is a list of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and ned for use as the burial-transit Due to (or as a consequence of) Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a P.O. I 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 Probably 4 □Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an has e 2 autopsy performed? certificate 1 Yes Division of Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 2× No 2 1 Tes 2 ER/Outpatient 3□ DOA within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of fnjury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Momicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and tille of certifier 29c. License number 47743 January, 7, 2004 30. Name and address of person who completed cause of described (Item 23a) (Type, Print) Sinni Hospital of Bultimore 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/200

Registrar

JAN 1 3 2004

			1_ State	artment of Health and Me artificate of Death	ental Hygie	_	
			Registrar 1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici	an	Carl Lawrence Richter	15	AMUARY	Day Yeer	04 3:35 PM
	/Medic Examin		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	
	Exami	ei	SAINET AGNES HEHLTHCARE	BALTIMORE		Cit	У
	Funeral Director		5. Social Security Number 212–10–8251 6. Sex 101 M 2 F 87 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	B. Date of Birth (Month, Day, Ye Sept. 18	9. Bi 9. 1916 Ma	thplece (State or Foreign ountry) ryland
	g ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	shov shov	5		sville			1 ☐ Yes 2 🛣 No
	28a-f	ect	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What C	ountry?
	with	ă	106 Hilltop Rd.	21228		U.S.A.	
	ns 23	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R	rify Yes or No-	14. Race - Am	
(0	r itar	F	Amed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 1 Method 4 Never Married 1 Yes, Green WW II	12	ican, etc.)	Black, Wh	
036	ours a	by	3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 🔼 No Specify:		Specify: Wh	1te
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show ha Madigal Examiner must be colified at	Completed	15. Decedent's Education 16a. Decedent's education (Specify only highest grade completed) (Giv.	edent's Usual Occupation e kind of work done during most of workin DO NDT use retired)	g 16l	b. Kind of Business	s/Industry
21	athin	du	Elementary/Secondary (0-12) College (1-4or 5+)	pervisor		Chemical	Co.
	lled v tygie her t		12 2 Su	18. Mother's Name	(First. Middle, Mai	iden Sumame)	
anc	ntail hed of	Be	Louis A. Richter		ret Heppo		
Z	houk d Me mark matic	²	19a. Informant's Name/Relationship (Type, Print) 19b. Maii	ling Address (Street and Number or Rural	Route Number, C	ity or Town, State,	Zip Code)
Maryland	nd 2 s lth an 27 is r trau		Carol L. Bowers - Daughter 106	S. Hilltop Rd., Cat	tonsville	e, Md. 21	228
	f Heal		20a. Method of Disposition 20b. Place of Disposition cametery, critical control of Disposition 20b. Place of Disposition 2	ematory or other place)		c. Location - City o	
E O	Page ent o nt; # ry or		1 M Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) Maryland	l Veterans Cem. Jan.	. 15,2004	Owings	Mills, Md.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic avent, the Madical Examiner must be notified at once.			22. Name and Address of Facility	71 7 I	D A	21117
m	Depa Impo		Afel. Zeblandt	Eckhardt Funeral (n Rd. Ov	vings Mil	ls, Md.
31.			23a. Pert1. Enter the rusease, or complications that caused the death. Do not en shock, or heart ailure. List only one cause on each line.	nter the mode of dying, such as cardiac or	respiratory arrest		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final SEPTICE V				21 DAYS
	/Medical Examiner		resulting in death) Due to (or as a consequence of):				5 . 2 4 \ 5
Ŋ,	Examiner		Sequentially list conditions. Pary leading to immediate b. Due to for as a consequence of):	TRACT IMFECT	1014		21 DAY
7	ed sit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events C.				
/	be executed sicien and burial-transit	xan	that initiated events c				
,09	sicier buria	7	d				
89	certificate iding physise as the	edic					
Box		Physician/Medic	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	☐Ectopic pregnancy		23d. Date of d	
	0 0 0	100	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month	Day Year
P.0	that the do	Phy	9 Unknown	and the second of Dead	23a Did tabar	and use contribute	to the cause of death?
	Se us	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.			Probably 4 Onknown
ord	w requires been sign should be	ted			-		
Records,	2 2	Completed			24a. Was an autopsy performe	prior to	autopsy findings available completion of cause of
<u>=</u>	the cate h				1□ Yes 2Ū	No 1 □ Ye	s 202No
Vit	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death		0 FOIL (0-	
Division of Vital		T.	1 Yes 2 No 10 Printer 1 Management 2 ER/Outpatie 27, Management Death 28a. Date of Injury 28b. Time	of 28c. Injury at 2	8d. Describe how	e 6 ☐Other (Sp inju ry occurred	өспу)
on	Attending Firdeath. sector: After by the funer	tlon	1 Satural 5 Pending (Month, Day Year) fnjury 2 Daccident investigation	Work? M 1 ☐ Yes 2 ☐ No			
/isi	al or Attendi after death. I Director: A d in by the fu	flca	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, s	street, factory, office	81. Location (Stree City or Town, S	et and Number or I	Rural Route Number,
Ö	2 2 2 2	Certification;	4 ☐ Homicide determined building, etc. (Specify)		City of Youri,	State)	
	e Hospital of 24 hours af the Funeral Dietely filled in		29a. Certifier Check only 2 Medical Exeminer: On the basis of examination and/or	ath occurred at the time, date and place, a	nd due to the caus	se(s) and manner a	as stated.
	To the Hos within 24 ho To the Fun completely i	Medical	one) and manner stated.				
	To Teo	2	29b. Signature and title of certifier	29c. License number		. Date signed (Moi	
	1 ~		K- Quintinesch MI)	00060105	, 3	AMUARY	+ 2004
	0		30. Name and address of person who completed cause of death (Item 23a) (Typi	e, Print) 20 CATOH AVENU	E RAI	TIMORE	MD 21229
		010	31. Date filed (Month, Day, Year) 32. Registrar's Signature	CVC TOTA TIVETA	, 011-		11-2 01-22
	St Regist	ate trar		will be			
D	MH 17 Boy 1/		the state of the s				

DHMH 17 Rev 1/2001

CARL

Physici		1 - Stata Ragistrar Amend ITe		fh G8	327 Cei	rtificate	of L	Jeath		2. Date of Month	Day		ear VVL	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution,	give street and number)			4b. City, To			of Death	munit		County of	Death	0.1
Funeral Director			1 □ M 257 F	e (In yrs. Ia	est birthday) Yrs.	Balti If Under 1	Year]	If Under : Hours	24 Hrs. Min.	8. Date of (Month,	Birth Day, Year)	25	Country	
υ		Usual Residence of Decedent 10a. State 10b. County			Town or Lo	cation				03	31	25		1D d. Inside City Limits
the Man 28a-fsh	Director	MD NA		Ва	ltimo	ore	nde.				10g Citi	izen of Wh	at Countr	XIXYes 2 □ No
sath with is 23a or	erai DI	608 North Ash	burton St		40.1		2:	1216				u.s.	A	<u>-</u>
USO urs after do al', or item Exeminer	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Armed Forces?			Was Deceden fYes, specify 1 □ Yes 2🎖			gin? (Spe i, Puerto I	city Yes or Rican, etc.)	No-	14. Race - Black, Specify:	American White, et	c.
Mal yidilid Z I Z I 3-0030 nd 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 Is marked other than "natural", or items 23a or 28a-1 show traumatic evant, the Madical Examinar must be nutified at	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5		(Give life. L	ient's Usual C kind of work o	done du retired)	uring most		ng		nd of Busin		,
be filed winter the dother the evant, me	Be	11th grade 17. Father's Name (First, Middle, La		(Custo	dial		18. Mothe	r's Name		dle, Maiden	n Ho Sumame)	pkir	ns
Maryian	<u>0</u>	Henry Milliga 19a. Informant's Name/Relationship		A	19b. Mailin	g Address (S	treet ar			arris Route Nu		r Town, St	ate Zip.C	gore21216
Pages 1 armon of Hearmont of Hearmont of Hearmont: If item 2 ury or other		Berdella Rich 20a. Method of Disposition X Burial 2 Cremation 3 4 Donation 5 Other (Spe 21. Signature of Puperal Service Lice	□Removal from State cify)	20b. Pla	er 60 netery, cren g Men	ob Nor sition (Name natory or othe norial	of r place, P a	ark	our 1/17	ate	20c. Lo	cation - Ci	alt1 ty or Town	Imroe Ma
permit. Departi		Syretto	5. Inne	2	43	Name and A rch F 800 Wa	bas	sh A	ve,			e Md	21	.215
Physician /Medical Examiner		23a. Pert1. Enter the disease, or co shock, of heart failure. List on Immediate Cause (Final disease or condition resulting in death)	ny one cause on each lin	Д\$	SIVE		f dying,	, such as o	cardiac o	r respiratory	arrest,		l Ir	pproximate nterval Between Inset and Death
cate be executed physician and the buriat transit	Examiner	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a		1	I.N.	1	<u>- 1 </u>	a					
certificate be execution and other as the burial-trail	edical		d			DIAE	3 6	IT t	<u>ES</u>					
the death y the atter iched for u	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 1	2 Fetel d	leath 3 🗆	Ectopic pregr Other (specil					2	3d. Date o Month	f delivery Da	ay Year
es tha	þ	Part II. Other significant conditions	contributing to death bu	t not result	ing in the un	derlying caus	e given	in Part I.				_		cause of death?
The law ate has b page 2 st	Completed									pe 1 □ Yes	topsy rformed? 2 No	dea	th?	r findings available letion of cause of ☐ No
Phys aldi	cation: To Be	25. Was case referred to medical examiner? 1 Yes 24 No 27. Manner of Death 1 Natural 5 Pending investigate 2 Accident 5 Could not	be	Year) 2	R/Outpatient 8b. Time of Injury	28c.	Other: Injury a Work? 1 Ye	4 □ Nur	sing Hom 2i	8d. Describ	esidence 6 e how injury	occurred		· · · · · · ·
vital or A urs after rai Dirac	Certifi	4 Homicide determine	building, etc.	(Specify)						City or T	own, State)			oute Number,
To the Hospital or Attending within 24 hours after death of the Funaral Director; After completely filled in by the funes	Medical	(Check only 2 Medical Expone)	Physician: To the best of amther: On the basis of and manner state	examinatio	edge, death n and/or inv	estigation, in	ny opir	, date and nion, death	place, ai	nd due to the	e, date and	place, and	due to the	e cause(s)
a = a □	-	29b. Signature and the of certifier	Male	- M	1. D.							signed (N		
To with		20. Name an address of parce with	ampleted cause of de	ath (Itam 2	(2a) (Tuna F	Drimt)						6	-	
or military of the state of the	te_	30. Name an address of perso when the state of the state	ompleted cause of de KSON MI 32. Registra	9	3a) (Type, F 200 re	orint)	É	BALT	ime	RE	St.	BA	LTIM	oo4 wore, mo

		For State Registrar	State of Mar	-	ertificate of		F	Reg. No.	0,0000
Physicia /Medica Examine	al .	1. Decedent's Name (First, Middle, Las ROBERT) 4a. Facility Name (If not institution, give	street and number)			or Location of Dea	2. Date of Dea Month Januar	Day	Year 10:30 A
Funeral Director		5. Social Security Number 214–26–6493 11	7. Age (E Q In yrs. last birthday 74 Yrs.	BALTI If Under 1 Year Months Days	If Under 24 Hr	. (Month, Da)	, Year) 6,1929	N/A 9. Birthplace (State or Fore Country) MD
Sa-f show	ctor	10a. State 10b. County N/A	1	Oc. City, Town or L		ore City			10d. Inside City Lim 1⊠Yes 2□I
23a or 2 unit be na	Funeral Director	1536 Clarkson St	reet		10f. Zip Code	2123		10g. Citizen of \	What Country? USA
	2	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4XX © vorced	12. Was Decedent Ev. Armed Forces? 1 ☐ Yes ※XX No If Yes, Give Year or Dates:	er in U.S.	Was Decedent of If Yes, specify Cut 1 ☐ Yes 2 ☑ No		Specify Yes or No- rto Rican, etc.)	14. Rac Blac Specify	ce - American Indian, ck, White, etc. y: White
the Medical	Completed	15. Decedent's Ed (Specify only highest grader) Elementary/Secondary (0-12)		(Give	edent's Usual Occu e kind of work done DO NOT use retire imore Cit	during most of world)			usiness/Industry City Police
arked other	To Be Co	17. Father's Name (First, Middle, Last) Robert W. Roberts				18. Mother's Na	me (First, Middle, ephine A	Maiden Suman • Twig	- Э
27 is ma er trauma	i	19a. Informant's Name/Relationship (7 Julia M. Dave	ype, Print) Y / Sister				Pural Route Number Baltimore		
rtant: If itan njury or oth		20a. Method of Disposition 1 ☐ Burial 2 XX remation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)	Bayview	Crematory or other pla	cy Jan	Date 15, 200		City or Town, State imore MD
any ir		21. Signature of Funeral Service Licen	Victor P. I	\ IQ	maries L. S	tevens run	eral Home, Baltimore	Inc. MD 21230	
ysician ledical aminer	Iner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	one cause on each line.	onsequence of):	Phen w		c or respiratory arr	est,	Approximate Interval Between Onset and Death 2 Wee
ysicia ne bur	edical Examiner	Cause (Disease or injury that indiated events resulting in death) Last	C	onsequence of):					
led by the attending phy detached for use as the	Pnysician/med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 [4 □ Pregnant at tirn 9 □ Unknown	☐ Fetal death 3 [⊒Ectopic pregnanc □ Other (specify) _	у		23d. Date Mor	e of delivery nth Day Year
ge pe	2	Part II. Other significant conditions co	entributing to death but r	not resulting in the u	underlying cause gr	ven in Part I.	23e. Did tot	_	ribute to the cause of death?
cate has	Completed						24a. Was a autops perform	med? d 2. No 1	Nere autopsy findings availab prior to completion of cause o feath? □ Yes 2□ No
this certi	10 0	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	2 ER/Outpatie	nt 3 DOA Ott	110000	ath (Check only on Home 5 ☐ Reside		er (Specify)
tor: After	Certification;	27. Manner of Death 1	28a. Date of Injury (Month, Day Y		M 1	ry at	28d. Describe ho	ow injury occurre	ed
To the Funeral Directompletely filled in by		4 Homicide determined	28e. Place of Injury building, etc. (Specify)			City or Towr	n, State)	er or Rural Route Number,
To the Funeral C	redical	one)	rsician: To the best of r iner: On the basis of ex and manner stated	amination and/or in	ivestigation, in my d	opinion, death occ	urred at the time, da	ate and place, a	and due to the cause(s)
To Con	The state of the s	29b. Signature and title of certifier	DENUE , 1	MD	29c. Licens	01.4	-		(Month, Day, Year)
State		30. Name and address of person who compared to the state of the state	DENOV 732. Registrar's	7.	15. HA	NOVER S	7. BAH	mo	- 12 100 21225

			For State Registrar	State of Maryla	nd / Dep		ealth and M	ental Hygi	_	00500
		26)	Decedent's Name (First, Middle, Last)					2. Date of Deat	h	3. Time of Death
	Physici /Medio	cal	Katie F.	Rogers		4b. City, Town, or	Leastion of Death	Month 1	6 04 4c. County of Deat	8 03PM
	Examir	er	4a. Facility Name (If not institution, give s							
			Randallstown Nu 5. Social Security Number 6. Sex			Randal If Under 1 Year	ISTOWN If Under 24 Hrs.	8. Date of Birth	Baltimo	
	Funeral Director			M 27 83	Yrs.	Months Days	Hours Min.	(Month, Day, 3-6-19	920 Vir	nplece (State or Foreign untry) ginia
	faryland show	or	10a. State 10b. County		ity, Town or L					10d. Inside City Limits Y☐ Yes 2 ☐ No
	28a-1	ect	Md. N/A		Baltir	10f. Zip Code		10	0g. Citizen of What Co	untry?
	with a or	2	2108 Penrose S	+		21223			USA	,
	ns 23	era		12. Was Decedent Ever in t	J.S. 13.	Was Decedent of His	spanic Origin? (Spe	ecify Yes or No-	14. Race - Ame	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23e or 28e-f show any injury or other traumatic event, the Medical Examina the notified at ance.	by Funeral Director	1 ☐ Never Married 2 ☐ Married Multiple Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates:		If Yes, specify Cubar 1 ☐ Yes 2 X No	Specify:	Rican, etc.)	Black, White	
21215-0036	in 72 ho n natur	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired,	uring most of worki	ng	16b. Kind of Business/	ndustry
212	r tha	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	Н	omemaker			Home	
ğ	othe	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, N	Maiden Sumame)	
<u>a</u>	Aenta Aenta rked tic e	ToE	Willian L.	Vandervel1	III,		Floren	ce B,	, Johns	on
Maryland	12 sho h and l 7 is ma trauma		19a. Informant's Name/Relationship (Type	-					City or Town, State, Z	
e,	1 and Health em 2 ther		Dr. Kevin A. Ro		Place of Dispe	osition (Name of			ore, Maryl 20c. Location - City or	
Baltimore,	Pages nent of ant: If it ury or o		1 X Burial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)	emoval from State	ruid l	matory or other place Ridge Ce	m. 1-1:		Baltimore	
Balt	permit. Departr Imports any inji		21. Signature of Funeral Service License LLOyd M. Fst	ep	2	2 Name and Address Estep Br 1300 Eut	others i aw Place	Funeral e.Balti	Ser,P.A imore,Md.	21217
	Pnysician /Medical Examiner		23a. Pert1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conse	1601	ter the mode of dying		r respiratory arre	est,	Approximate Interval Between Onset and Death
8760,	cate be executed oblysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Either Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse						
.O. Box 68	that the death certificate ed by the attending phys detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregr 1 □Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	tel death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of deli Month	very Day Year
ď.	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditions con			underlying cause give	n in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ğ	w require been sig should b	ed	DEMENTIA	1 51	2010			1 □ Ye	s 2□No 3□Pro	bably 4 Cunknown
Vital Records,	0 - 0	Completed		\				24a. Was ar autopsy perform 1 Yes 2	y prior to death?	topsy findings available ompletion of cause of
<u>ta</u>	ician: Th certificate rector, pag	4	25. Was case referred to medical				26. Place of Death			
	S 5	To B	examiner?	ospital: 1 Inpatient 2 [□ER/Outpatie	nt 3 DOA Othe	4 Hursing Ho	me 5 Reside	nce 6 Other (Spec	ify)
ion of	ding After fune		27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yeer)	28b. Time o Injury	Work	at ? ′es 2 □No	28d. Describe ho	w injury occurred	
Division	ai or Atto s after de ni Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec		reet, factory, office		28f. Location (Str City or Town	reet and Number or Ru , State)	ral Route Number,
1	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical (29a. Certifier Certifying Physical Control (Check only one)	sician: To the best of my kr ner: On the basis of examin and manner stated.	nowledge, deal nation and/or in	th occurred at the tim nvestigation, in my op	e, date and place, inion, death occurr	and due to the ca ed at the time, da	tuse(s) and manner as ate and place, and due	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	//		29c. License	number	29	9d. Date signed (Month	Day, Year)
	٨		· 111	10/10	No	109	5336	0	1/8/0	9
ر				ENE IT	REE	Print) CUL	S12 5	SAMO 300	PRICESVIL	13 M2 M201
45	Sta	ate	31. Date filed (Month, Day, Year)	3 2004 Sign	nature	1 STRAGE	P			

	1 - For State Registrar	State of Maryland	/ Department of Health and Certificate of Death	Mental Hygien	* * * * * * * * * * * * * * * * * * * *
Physician /Medical Examiner	THINGD I	Middle, Last)	4b. City, Town, or Location of Dea	2. Date of Death Month D	3. Time of Death 3. Time of Death 12:30 F M C. County of Deeth
Funeral Director	5. Social Security Number	Specialty Hospital 6. Sex 102M 20 F 7. Age (in yrs, las	Bultimore st birthday) If Under 1 Year If Under 24 Hrs Yrs. Months Days Hours Min		9. Birthplace (State or Foreign MOD MUNICALITY) AND
the Maryland 28a-f show	Usual Residence of Decede 10a. State 10b. Co		Town or Location HimOre 10f. Zip Code	10a. C	10d. Inside City Limits 1 ☐ Y6s 2 ☐ No itizen of What Country?
fiter death with the Maryle freams 23s or 28s-f shot merinest be rediffed at Functional Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (self Yes, specify Cuban, Mexican, Puer	4	14. Race - American Indian, Black, White, etc.
21215-0036 ed within 72 hours after death with the Maryland set than "natural", or Itams 23a or 28a-f show it the Medical Ever distrinst be notified at Completed by Funeral Director	3 ☐ Widowed 4 ☐ Dive	orced If Yes, Give Year or Dates: redent's Education highest grade completed)	1 ☐ Yes 2 ☐ No Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of work iife. DO NOT use retired)	orking 16b. I	Specify: Black' Kind of Business/Industry
O Date	17. Father's Name (First, Mi		SKIII Laborer 18 Mother's Na Man	me (First, Middle, Maide	TEE/ n Surname)
Mary nd 2 sho lith and 27 la m	19a. Informant's Name/Rela) - FAther 20b. Plac	ce of Disposition (Name of	Balto, mo	or Town, State, Zip Code) & 1223 .ocation - City or Town, State
Baltimore, permit. Pages 1 at Department of Heal Important: If tiem any injury or othanone.	1 D Burial 2 Grema 14 Donation 5 Ott	ner (Specify)	7100 Cemetery, crematory or other place) 2100 Cemetery 22. Name and Address of Facility 22. Name and Address of Facility		osdowne, mb
wate be executed and interpretation and the buriat-transit the buriat-transit and dical Examiner	shock of heart failure. Immediate cause (Final disease of condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	List only one cause on each line. A DX I L Due to (or as a conseque)	disorder nce of):		Approximate Interval Batween Onset and Death 3 month.
P.O. Box 6876 that the death certificate be ed by the attending physicis detached for use as the bu	IF FEMALE: 23b. Was decedent pregnal in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		eath 3 □Ectopic pregnancy		23d. Date of delivery Month Day Year
cords, P.O. w requires that the been signed by the should be detache	Part II. Other significant co	nditions contributing to death but not resulti	ng in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
Vital Record Idian: The law requir certificate has been s rector, page 2 should Be Completed		adical	26 Bless et Do	24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
ision of the standing Physical distributions the funeral distribution (catlon: To	examiner?	Hospital: 1 Impatient 2 EF 28a. Date of Injury (Month, Day Year) 28d. Very location of be 28e. Place of Injury - At home	Production 3 DOA Other: 4 Nursing Page 18b. Time of Injury M 1 Yes 2 No	Home 5 Residence 28d. Describe how inju 28f. Location (Street a.	ny occurred and Number or Rural Route Number,
To the Hospital or Al within 24 hours after To the Funaral Direct Completely filled in by Medical Certiff	4 Homicide 4 Homicide 29a. Certifier (Check only 2 Merone)	rtifying Physician: To the best of my knowle	edge, death occurred at the time, date and place n and/or investigation, in my opinion, death occ	City or Town, States, and due to the cause(surred at the time, date an	and manner as stated.
To the within To the complete complete Median Media	29b. Signature and title of co	entitier to the terminal of th	29c. License number D34974 3a) (Type, Print) Orath Charles Stros	, Ja	n, 13th 2004
State Registrar	Or Date Glad (Month Day	Year) JAN 1 3 200			

			1 - State Amend Item#1per	State of Ma PHYG827 1/1:	nyland / Depa 3/04 EW <i>Cei</i>	artment of F rtificate of a	lealth and M Death		ene g. No. 4 4 4 4	00576
	Physici	an	1. Decedent's Name (First, Middle, Last)	DOLLO	aline Rakowsk			2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Doris Saline Rako		s Saline Rak			JAN.	7, 2004	1:30 P M
	Examin	er	4a. Facility Name (If not institution, give s 2829 LODGE FARM R			EDGEM	r Location of Death ERE		4c. County of Death BALTIMORE	
K.	Funeral Director		Social Security Number		(In yrs. last birthday) 72 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec 31,	9 Birtho	lace (State or Foreign stry) yland
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation			1,	0d. Inside City Limits
	Maryli f eho	lor	MD Baltimon	re	Dundalk				'	1 ☐ Yes 2 ☑ No
	r 28a	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Coun	ntry?
	23a c		2036 Kelmore Road			21222			United Stat	.es
Maryland 21215-0036	within 72 hours after death with the Maryland jiene. rthan "natural", or Items 23a or 28a-f ehow the Madical Exactine roust be notified.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent & Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	0	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Whit	etc.
5-0	72 ho	etec	15. Decedent's Educ (Specify only highest grade		(Give	ient's Usual Occup	durina most of worki	na	6b. Kind of Business/Inc	•
121	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	oo NOT use retired ing Assis			Health Care	
d 2	H F F	Be Co	17. Father's Name (First, Middle, Last)		Nul 5.	ing Assis	18. Mother's Name	(First, Middle, M	aiden Sumame)	
ılan	o the D	To B	George Smith				Margaret	Frances	Monroe	
lary	and aum		19a. Informant's Name/Relationship (Ty)						City or Town, State, Zip	Code)
	s 1 and 2 if Health item 27 I		Chester Michael R	akowski,J	c/Son 414]					
Baltimore,	es of of		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)		Chesapea	ake Crema	e) tory	Jan 12	Oc. Location - City or To Beltsville,	
Bal	permit. Pag Department Important: any injury o		21. Signature of Funeral Service License	ne ann	100382	8717 Gree	n and Fund en Pasture	es Drive	Baltimore	, MD
	Physician /Medical Examiner	J.	23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	Due to (or as a	the death. Do not entered to the death of th					Approximate Interval Between Onset and Death
(8260)	ificate be executed g physician and as the buriat-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last		consequence of):	100 10				
	± 00 m	/Med	IF FEMALE:	De Marie esterme	7			35/		
.O. Box	that the death certiffed by the attending detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 KUnknown	3c. If yes, outcome of 1□Live birth 2 4□Pregnant at 9□Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ry Day Year
ords, P.	The law requires that the te has been signed by the has been signed by the sage 2 should be detache	þ	Part II. Other significant conditions con	tributing to death bu	t not resulting in the un	nderlying cause give	en in Part I.	10 .	cco use contribute to the	
of Vital Records,		Completed						24a. Was an autopsy performe 1 X Yes 2	prior to con death?	esy findings available apletion of cause of
Σ	Physician: This certificatal director, p	o Be	25. Was case referred to medical examiner? 1 Yes 2 □ No	ospital: 1	nt 2 ER/Outpatient	3 DOA Othe	26. Place of Death		ce 6XXX ther (Specify,	אידי ככביאוני
	ding After fune	tion: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injun (Month, Day	28b. Time of	28c. Injury Work		8d. Describe how		AI SCENE
Division	25-5-6	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc.	ry - At home, farm, stre (Specify)	eet, factory, office	2	28f. Location (Stre City or Town,	et and Number or Rural State)	Route Number,
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 ☐ Certifying Phys (Check only one) 2 ☑ Medical Exemin	icien: To the best o er: On the basis of and manner stat	examination and/or inv	occurred at the time estigation, in my op	e, date and place, a pinion, death occurre	and due to the cau and at the time, date	se(s) and manner as sta a and place, and due to	ited. the cause(s)
)	To the To the comp	Ň	29b. Signature and title of certifier Za Linito 2	AR"		29c. License	.M.E	290	JAN 9, 2	
_	2		30. Name and address of person who con ZABINLLAH	AU	111 Penn		Baltimor	e. Marvla	and 21201	
	Sta Registr		31. Date filed (Month, Day, Yeer) JAN 1	32. Registra 3 200	ragnature	V. Common	7		500	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 05 Day Month 2004 Year **Physician** Richter Jan 01:49 A M James /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country)
 MD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 50 Months 1 X M 2 □ F 213-64-1865 Director Usual Residence of Decedent 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
and: If Item 27 is marked other than "natural; or Items 23a or 28a-1 show any or other than that be notified at any or other transactic event, the Marcial Examine marks and the national contents. 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Edgewater Directo Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21037 221 Braxton Way U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 NSA Dept. Of Defense 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Alva Richter Edna Hopper ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 221 Braxton Way Edgewater, MD 21037 Mrs. Shirley Richter/wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permil. Page Department of Important: If any injury or Stevensville, MD 4 □Donation 5 □Other (Specify)

1. Signatury of Service Licensey Chesapeake Cremation 2004 22 Name and Address of Facility Singleton Funeral Home, P.A. 21. Signatu Second Avenue Glen Burnie, MD 21061 23a Pyrt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imr ediate Cause (Final disease or condition resulting in death) Pulu Physician I Die Pa /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an director, page 2 certificate has 1 Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA his funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner eath 28b. Time of 28d. Describe how injury occurred Alter I 5 Pending 1 atural Injury 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the the 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 11005829 05 04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO 1000b towas (0) 31. Date filed (Month, Day, 32. Registra Signature State osele Registrar

				For State Registrar	tate of Man			t of H	ealth and	Mental Hy	_	ible.	00576
		Physici /Medic		1. Decedent's Name (First, Middle, Last) JENNIE SHAW						2. Date of De Month Januar	Day	Year 2004	3. Time of Death 10:45p ^M
		Examir	ner	4a. Facility Name (If not institution, give stre 155 S. Grundy S 5. Social Security Number 6. Sex	creet	n yrs. last birthday)	**	ltir	Location of Deat NOTE If Under 24 Hrs		n/a		Jana (Chata or Forniga
		Funeral Director		215-14-8244 1 M Usual Residence of Decedent	2 ⋉ F 8	1 Yrs.	Months	Days	Hours Min.		ÿ, Year) 1922	Bal	lace (State or Foreign htry) _timore, MI
		with the Maryland a or 28a-f show Les notified at	ector	MD 10b. County n/a 10b. Street and Number	10	Baltimo	re	Code			10a Citiana at		0d. Inside City Limits 1 XYes 2 □ No
E.	036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Pygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, The Madical Examinar must be motified at angles.	by Funeral Director	155 S. Grundy S	treet Was Decedent Eve Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:	1		224 ent of Hi rfy Cubar		Specify Yes or No- to Rican, etc.)		ce - Americ ack, White, of	an Indian, etc.
SHA	21215-0036	filed within 72 ho Hygiene other than "naturent, the Medical	Be Completed	15. Decedent's Educat (Specify only highest grade of Elementary/Secondary (0-12) 3rd	on ompleted) College (1-4or 5+)		lent's Usua kind of won DO NOT us 10 WO	k done d e retired)	uring most of wo		Polin Umbre	& Ka ella	tz
SINA	Maryland	should be fill and Mental H is marked ott	To Be	17. Father's Name (First, Middle, Last) Vincenzo D'An	-				Rosa	me (First. Middle, ria Mac	aione		
3	-	and 2 sh ealth and n 27 Is m		19a Informant's Name/Relationship (Туре, Mario Teresi		392	6 E.	Pr		ural Route Numbe ., Balt			
1 1	Baltimore	mit. Pages 1 bartment of Hi cortant: If iter injury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Rem '4 □ Donation 5 □ Other (Specify)	1	20b. Place of Disposicemetery, crem St. Sta	natory or ot	^{her place} aus	1/14	1/2004		nore,	MD
	Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licensee	men S	S 26	3 S.	Co	nklina	seph N St. Ba	ltimor	nino ce. M	Jr. FH D 21224
		Physician /Medical Examiner		23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one disease or condition resulting in death) Sequentially list conditions	Due to (or as a co	NOMA	or the mode	of dying	, such as cardiad	C or respiratory ar	rest,		Approximate Interval Between Onset and Death
	68760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	Due to (or as a co								
	P.O. Box 6	that the death certifice ed by the attending ph detached for use as th	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 0 No 9 □ Unknown	If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pre Other (spe					ate of deliver	ry Day Year
	rds, P	w requires that been signed b should be deta	ed by Pł	Part II. Other significant conditions contrib	uting to death but no	ot resulting in the un	derlying ca	use give	n in Part I,	23e. Did to	36	tribute to the	e cause of death?
	al Reco	: The law recate has bei	Completed							24a. Was a autop perfor 1 Yes	sy med?	prior to con death?	psy findings available apletion of cause of
	Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the	tlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hose 27. Manger of Death 1 Natural 5 Pending 2 Accident investigation	oital: 1 Inpatient 8a. Date of Injury (Month, Day Ye	2 ER/Outpatient 28b. Time of Injury		Othe Ic. Injury Work	r: 4 🗆 Nursing H	ome 5 Residence 28d. Describe h	ence 6 Oth)
	Divisi	al or Atter s after dea il Director	Certification:	a Double & Could not be	8e. Place of Injury - building, etc. (S	At home, farm, stre	et, factory,	office		28f. Location (S City or Tow		ber or Rural	Route Number,
		he Hospit n 24 hours he Funera bletely fille	Medical C	29a. Certifier (Check only one) 1 Certifying Physici	an: To the best of m On the basis of exa and manner stated.	ımination and/or inv	occurred a estigation,	t the time in my op	a, date and place nion, death occu	, and due to the c rred at the time, c	ause(s) and malate and place,	anner as sta and due to	ated. the cause(s)
		To ti Withi To ti comp	Ň	29b. Signature and title of carritor.	exell h	rð.	29c.	CO (16188	2	29d. Date signe	d (Month, E) - 12	Pay, Year)
				30. Name and address of rson to comp WALKEN TMP AT 31. Date filed (Month, Day, Year)	CIATE	41 17	Print) S. E	FATO	on St.	BARTI	40RE,	hij	21224
		Sta Registr		IAN 1 3 2004	32. Registrar's	H Anna	8			{	,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jan. 8, 2004 **Physician** 12:15p M Charles Jacob Scholl /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2116 Spencer Lane Finksburg Carroll If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth
(Month, Pay, Year)
June 6, 1923 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**%** M 2□ F 80 183-18-5551 Pennsylvania Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, it a Medical Examinar inval to notified at 1 Yes 2 No Md. Carroll Finksburg Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21048 2116 Spencer Lane U.S.A. Funeral 12. Was Decedent Ever in U.S. Amged Forces? 1 Pres 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 WW II 1 ☐ Yes 2 No λq Specify Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if I tem 27 is marked other than "many injury or other traumsting." Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Man Bowling 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Raymond Leroy Scholl Anna N. Stouffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Bernice Scholl -Wife 2116 Spencer Lane, Finksburg, Md. 21048 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State \$ Burial 2 □ Cremation 3 □ Removal from State Evergreen Mem. Gardens Jan. 10, 2004 Finksburg, Md. * 4 □ Donation 5 □ Other (Specify) 21. Signature of Fine at 1 ervice Licenses 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Rd., Owings Mills, Md. 21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Idiopathic Physician Pulmonary OTE MOST /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Examiner The law requires that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit Due to (or as a consequence of) Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 certificate has been signi rector, page 2 should be 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident the 1 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) I in by t 4 Homicide filled 1 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0059943 2004

DHMH 17 Rev 1/2001

State

Registrar

50th 307

Westminster,

21157

MO

Stoner

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

295

32. Registrar's Signature

John C. Abel, Mio

MAN 1 3 2004

31. Date filed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

GUP TA

82 Registrar's Signature

18 LARS

201-109 BACK RIVER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHAKUN MHL

31. Date filed (Mostly, Day, Year) 2004

2004 SUN 2004

NECLIRO

BALTIMORE

	_	For State Registrar	State of Maryland /		rtment of H		Reg	ene J. No.	4 020 0
Physicia		1. Decedent's Name (First, Middle, Last, LESTER	JEROME		STENI	NETT	2. Date of Death Month JANUAR	Day Ye	3. Time of Death
/Medic Examin		4a. Fecility Name (If not institution, give HARBOR HOS	street and number)			Location of Death		4c. County of D	
Funeral Director		5. Social Security Number 6. Se		birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8 Date of Birth (Month, Day, $1/1/25$	0	Birthplece (State or Foreign Country) N.J.
Q.	tor	Usual Residence of Decedent 10a. State 10b. County Maryland N/a	10c. City, To	own or Lo		ltimore			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
with the te or 28a Lee notil	Director	10e. Street and Number 2450 Nevada Street			10f. Zip Code	21230	10	g. Citizen of What U.	Country? S.A.
within 72 hours after death with the Maryland jiene. Than "naturel", or items 23s or 28s-f show the Modical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1945		Was Decedent of Hi f Yes, specify Cubar I ☐ Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specity:	ecify Yes or No- Rican, etc.)		merican Indian, /hite, etc. Black
within 72 hours aftene. Then "natural", or	Completed	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12)		6a. Deced (Give life. L	lent's Usual Occupa kind of work done o DO NOT use retired Bel	ation furing most of work) t Man	ing 1	6b. Kind of Busine Chessie Ra	ess/Industry all Road System
0 0 0	To Be C	17. Father's Name (First, Middle, Last) Lester C.	Stennett			18. Mother's Name	e (First, Middle, M Laura	colberth	
nd 2 shoulth and N 27 is mai		19a. Informant's Name/Relationship (T) Rose Stennett Wife	vpe, Print) 1	9b. Mailin 24	ng Address <i>(Street a</i> 50 Nevada S	and Number or Run treet Baltimo	al Route Number, re, Maryland	City or Town, Star 21230	e, Zip Code)
- ± = 5		20a. Method of Disposition 1 🗡 Burial 2 □ Cremation 3 □ to 4 □ Donation 5 □ Other (Specify,	Removal from State	itery, cren	sition (Name of natory or other place rest Veterans	θ)	01/16/04	Oc. Location - City Owings M	or Town, State ills , Maryland
permit. Pages Department of Important: If if any injury or once.		21. Signature of Funeral Service Licens	14		Name and Addres Estep Bi 1300 Eu				
Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the death. In ecause on each line. a. PULMONF Due to (or as a consequent	HRY	EMBO	OLISM		st,	Approximate Interval Between Onset and Death
Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. MYCCARI Due to (or as a consequence METASTA	ce of):		ARCTIO		£	72 hours
licate be executed physician and is the burial-transit	dical Exan	that initiated events resulting in death) Last	Due to (or as a consequent			17(120	GIVEL		Je
death certi	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de: 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
quires that n signed build be deta		Part II. Other significant conditions of	ntributing to death but not resultin	g in the u	nderlying cause give	en in Part I.	23e. Did toba	/	e to the cause of death? Probably 4 Unknown
vical necolus, r ician: The law requires that the certificate has been signed by th rector, page 2 should be delache	Completed							ed? prior deat	
ysician: ysician: is certific director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1. ☑Inpatient 2☐EP	Outpatier	nt 3 DOA Othe	or	h <i>Ch</i> eck only one ome 5 ☐ Resider		Specify)
Attending Physician: r death. ector: After this certification the funeral director.	ı — ı	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		b. Time of Injury	f 28c. Injun World		28d. Describe how		. ,
DIVISION OF VICES ei or Attending Physician: 1 atter death. t Director: After this certificat din by the funeral director, p	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, str	eet, factory, office		28f. Location (Str. City or Town,		r Rural Route Number,
To the Hoxpitel or Attent within 24 hours after deatl To the Funerat Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Phr (Check only one) 2 Medical Exert	ysician: To the best of my knowle iner: On the basis of examination and manner stated.	dge, deati and/or in	h occurred at the tim vestigation, in my o	ne, date and place, pinion, death occur	and due to the car red at the time, da	use(s) and manne te and place, and	r as stated. due to the cause(s)
To the I within 2 To the	M	29b. Signature and title of certifier			29c. License			d. Date signed (M	
		Hirut Co	Chrewold Wompleted cause of death (Item 23	1 D		5 001		HNUARY	
St	ate	HIRUT GEBRE 31. Date filed (Month, Day)	114	So	UTH HE	HNOVER	STREET,	BALTIN	ORE MD 2122

D			State of Maryland /	Depa	artment of H	lealth and N	-	_	ie.	21/0/27/97
			#23a-b&27 per me	C827	tifldat8/8/	Death		g. No.	,	Co Co Co Co
Physic /Med		Decedent's Name (First, Middle, La Michelle	M. Simpers				JANUARY		Year)4	3. Time of Death
Exam		4a. Facility Name (If not institution, given	re street and number)		4b. City, Town, o	r Location of Death		4c. County of	f Death	
		VA MEDICAL CENTER		tak dal	PERRY PO		0. Date of Righ	CECIL	O Blab	Inna /Chaha as Fassion
Funera Directo			7. Age (In yrs. last bi	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Nov. 17,	Year) 1961	Buffa	lace (State or Foreign try) NY
Maryland -f show	tor	10a. State 10b. County	10c. City, Tov	wn or Lo	cation F1ktc	n			1	0d. Inside City Limits
with the 3a or 28a	i Direc	10e. Street and Number 202 Prairie Drive	e, Apt B		10f. Zip Code	21921	10	g. Citizen of W		otry? 3 States
ife, Maryland 21215-0030 s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural; or items 23s or 28s-f show other traumatic svent, the Medical Examinar must be redified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4450 Norced	12. Was Decedent Ever in U.S. Armed Forces? 1.182 Yes 2 1 No 14 Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub	dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		, White,	an Indian, etc. white
Z I Z I 3-0030 od within 72 hours atl gjene. sr than "natural", or tra Medical Exam	Completed	15. Decedent's E (Specify only highest gr	ducation 16a	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of work	king	6b. Kind of Bus	siness/Ind	dustry
within ene.	dwo	Elementary/Secondary (0·12)	College (1-4or 5+)		Payroll Cle			U.S. N	avy	
d be filed within ental Hygiene.	To Be Co	17. Father's Name (First, Middle, Las Richard S. Jaboz					e (First, Middle, M aryanne Kr)	
Maryland of 2 should be file lith and Mental Hy 27 is marked oth	F	19a. Informant's Name/Relationship Maryanne Kasprzyl		_	_	and Number or Rui		City or Town, S	state, Zip	Code)
O 82=5		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Speci	Removal from State	ery, crei	esition (Name of matory or other pla	ce) 01 /	Date 2	oc. Location - 0	alo,	
Dalling permit. Pa Departmen Important: sny injury			nsee Victor P. Doda, Ji	- Lu	2. Name and Addre	ess of Facility Stevens Fund t Avenue, E	eral Home,	Inc.	21230)
S8760, Cate be executed Wedica Examine buysician and burial-transit sthe burial-transit	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Coronary Tl Due to (or as a consequence Atheroscler Due to (or as a consequence c. Due to (or as a consequence d.	e of): roti e of):		vascular	Disease			Onset and Death
death certif	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ yes 2 ☐ No 9 ☑ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown		□Ectopic pregnanc □ Other (specify)	у		23d. Date Mon		ory Day Year
T tat tag	þ		contributing to death but not resulting	in the u	nderlying cause gr	ven in Part I.	23e. Did tob 1 ☐ Ye		bute to th 3 🗌 Prob	ne cause of death? ably 4 Unknow
The The page	Completed						24a. Was ar autopsy perform 1 Yes 2	/ 01	ior to con	psy findings available mpletion of cause of
VICIAN: The certificate rector, pag	Be	25. Was case referred to medical examiner?	Hopoteli		0.4		th (Check only one)		
Physi Physi this c	5	Yes 2 No	Hospital: 1 ☐ Inpatient 2 X ER/C	Outpaties . Time c	nt 3 DOA	The state of the s	ome 5 Reside			y)
Afte tune	Certification:	1 Natural 5 Pending 2 Accident Investigate 3 Suicide 6 Could not determine	on Blood of Injury At home in	Injury	M 1 [Yes 2 □ No	28f. Location (Str City or Town	eet and Numbe		Il Route Number,
Hospita 4 hours Funeral	Medical Ce	29a. Certifier 1 Certifying F (Check only one) 2 Medicel Exa	Physician: To the best of my knowledgeminer: On the basis of examination a and manner stated.	ge, deat and/or in	h occurred at the ti	ime, date and place opinion, death occu	, and due to the ca rred at the time, da	use(s) and mar te and place, a	ner as si	tated. the cause(s)
To the within 2 To the complet	Mec	29b. Signifure and title of certifier	melhue u	N).	0.0	se number		d. Date signed		
		30. Name and address of person who	A. KORELL		111 Penn	Street,	Baltimore	e, Mary	Land	21201
₹ S	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signature		& Kon	1 10° 1				

B.K.S LE

		FOUNDEND AND AMEND State Registrar								2. Date of Dea				3. Time of	
Physician	_	I. Decedent's Name (First, Middle, Las	Sco	++ T	FANEIL	SCOTT				Month	Day	2004	reer	0929	
/Medical		a Facility Name (If not institution give			371/1111		Town, or	Location of	Death	JAIN.		County of	Death	0020	
Examiner		a. Facility Name (16 not institution, giv. 3329 ELMORA AVE	NUE					ORE CI				N/A			
Funeral Director	5	5. Social Security Number 6. S 216-86-0401	ex 7. A		. last birthday) Yrs.	If Under Months		If Under 2 Hours	4 Hrs. Min.	8. Date of Birth 8 – 13 – 6	S T		Birthp BaI	lace (State of try) timon	or Foreign ce, Mc
2 007	-	Jsual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	ocation							1	0d. Inside C	ity Limits
show					Balt	imor	•							1 X Yes	2 🗌 No
ritems 23e or 28e-f si riner must be notified Funeral Director	2	Md. N/A			Dare	10f. Zip				1	0g. Citi	zen of Wh	at Cour	ntry?	
Sa or	5	3329 Elmora	Ave.			2	2121	3			USA	A			
L L		11. Marital Status	12. Was Decedent Armed Forces	Ever in U	J.S. 13.	Was Dece	dent of Hi	spanic Orig	in? (Spe Puerto	cify Yes or No- Rican, etc.)			- Americ White,	ean Indian, etc.	
A 45	2	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □Yes 2 X If Yes, Give Year or Dates:	No		1 ☐ Yes		Specify:				Specify:	В1	ack	
it, the Medical E		15. Decedent's Ed (Specify only highest gra	ducation ide completed)		16a. Dece (Give	dent's Usu kind of wo	al Occupa	ation during most	of worki	ng	16b. Ki	nd of Bus	iness/In	dustry	
7 is marked other than "r traumatic event, the Mad To Re Comple	-	Elementary/Secondary (0-12)	College (1-4or	5+)							т	Tour	_		
4 0	3 -	12 17. Father's Name (First, Middle, Last,)		HC	useh	lusb		's Name	(First, Middle,		Hous Sumame			
ed off	ă		t Sr.						olet	_					
matic	=	James Scot			19b. Maili	ng Address	s (Street a			I Route Numbe			tate, Ziç	Code)	
rtrau		Marcia Scott	Wife		332	29 E1	lmor	a Ave	e, Ba	altimo	ce, l	Md.	212	13	
other tra	-	20a. Method of Disposition			Place of Dispo	osition (Na matory or c	me of other plac	e)		ate	20c. Lo	cation · C	ity or To	own, State	
ry or		1 Donation 5 Other (Special Cremation 3 €			t. Žic	n Ce	em.	·	1-9-	-04 I	Lans	sdro	wne	,Md.	
Importent: If ite any injury or otl once.		21. Signature of Funeral Service Lice Lloyd M. Est	en		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2. Name a Ster 300	nd Addres Br Eut	othelaw P	rs I lace	Funeral e,Balt	l Se	er,P re,M	$d^{A}_{\cdot 2}$	1217	
100		23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that cause one cause on each	ed the dea	ath. Do not en	ter the mod	de of dyin	g, such as	cardiac c	or respiratory arr	est,			Approxima Interval Be	tween
sician		Immediate Cause (Final disease or condition			ID ALCOHO	L INIC	XICAT	ION						Onset and	Death
edical		resulting in death)	Due to (or a	s a conse	equence of):				-						
niner		Sequentially list conditions,	b	C10/17/18/29											
ig c	III e	n any, reading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (Ur a	S & SUNSO	кравное от).										
burial-transit	Xan	that initiated events resulting in death) Last	c. Due to (or a	s a conse	equence of):										
	olcar	•	_ d												
d s	0 -	IF FEMALE:													
tached for use as the second of the second o	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcom 1□Live birth 4□Pregnant 9□Unknown	2 □Fe	tal death 3	□Ectopic p □ Other (s						23d. Date Mont		•	Year
detac	2	Part II. Other significant conditions	contributing to death	but not re	sulting in the u	underlying	cause giv	en in Part I.		23e. Did to	bacco u	use contrit	oute lo t	he cause of	death?
P P	D D									1 🗆 Y	es 2	□ No 3	3 🗌 Prol	pably 4	Unknown
should	Completed									24a. Was		24b. W	ere auto	psy findings	available
page 2	E									autop perfor 1 Yes	sy med? 2 □ No	de	ath?	mpletion of ⊕ 2 □ No	cause or
rector, p	S L	25. Was case referred to medical						26. Place	of Death	h (Check only o					
g 5	0	examiner?	Hospital: 1 Inpa	tient 2 i	☐ ER/Outpatie	nt 3□D	Oth Oth	er: 4 🗌 Nu	rsing Ho	me 5 Resid	ence	6 ∭ Øthe	(Speci	y AT S	SCENE
		27. Manner of Death 1 Natural 5 Pending	28a. Date of In found	jury ay Year)	28b. Time of	of	28c. Injur Wor	y at k?		28d. Describe h		ry occurre	d		
ctor: Al	Certification:	2 Accident investigation	1-04-04		9:20a	М		Yes 2 (X)		UNKN					
Director:	Ě	3 Suicide 6AACould not l 4 Homicide determined	28e. Place of I building,	njury - At etc. <i>(Spe</i> c	home, farm, st	treet, factor	ry, office			28f. Location (S City or Tox	m, State	9)			nber,
led ir					T HOME					3329 ELMO					
To the Funeral Direct completely filled in by	edicai	29a. Certifier 1 ☐ Certifying P (Check only one) 2 ☑ Medical Exa	hysician: To the beaminer: On the basis and manner	of exami	nation and/or i	nvestigation	n, in my o	pinion, deal	th occurr	red at the time,	date and	d place, a	nd due t	o the cause((s)
o the	Mec	29b. Signature and title of certifier	217 11211101			29	9c. Licens	e number			29d. Da	te signed	(Month,	Day, Year)	
F 8			meus	KO.	Ó		0.0	.M.E			JAI	V. 5	, 2	004	
	-	30. Name and address of person who	- , ,			, Print)									

			For State Registrar	State of Ma	aryland /	•	tificat				Reg. No.	out feet to the	CHO OH S
	* *		1. Decedent's Name (First, Middle, Last)						2. Date of D Month	Day	y Year	3. Time of Death
	Physicia /Medic		JANE LEE SUHR							JANUAF			7:10 P.M
	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City,		Location of Dear	th	4c.	County of Death	
J			MANOR CARE RUXTO				If Under		OWSON If Under 24 Hrs	0. Data of D		BALTI	
	Funeral Director		5. Social Security Number 6. Se 15 219-34-4604	x 7. Ago	e (in yrs. last i 84	Yrs.	Months	Days	Hours Min		ay, Year) 19 1 9	9. Birti Coi MA	nplace (State or Foreign untry) RYLAND
	D.		Usual Residence of Decedent		10 0 T								10d. Inside City Limits
	trylar show	_	10a. State 10b. County		10c. City, To		cation						1 ☐ Yes 2 ☑ No
	8a-f	Directo	MD BALTIMO)RE	100	SON	101 70	0.1			10- 04	izen of What Co	
	or 2	급	10e. Street and Number				10f. Zip				Tog. Cit	IZEN OF WHAT CO	unity:
	ath v	rai	1418 AUTUMN LEAF	ROAD	Fuer in H.S.	112.1	Man Dann	21286	onania Origin? /9	Specify Vac or N		JSA 14. Race - Ame	ncan Indian
	er de	Funerai	11. Marital Status	12. Was Decedent Armed Forces?		13.	f Yes, spe	cify Cubar	n, Mexican, Puer	Specify Yes or N to Rican, etc.)		Black, White	
30	rs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ N If Yes, Give X Year or Dates:	40		1 🗌 Yes	2 X No	Specify:			Specify: WH	TTE
215-0036	be filed within 72 hours after death with the Maryland tal Hygiene dother than "natural", or items 23a or 28a-f show event, the Medical Exatul or trial to notified at	edt	15. Decedent's Edu		16	Sa. Deced	ient's Usu	al Occupa	ition uring most of wo		16b. K	ind of Business/	
Ü	in 72	Completed	(Specify only highest grad	de completed) College (1-4or 5		(Give	kind of wo DO NOT u	rk done d se retired,	uring most of wo	nking			
212	iene r tha	mo	Elementary/Secondary (0-12) 12TH GRADE	College (1-40)	,+1	PACK	ER				GOVE	ERNMENT	CONTRACTING
	be filed tat Hygi d other event, I	Be C	17. Father's Name (First, Middle, Last)						18. Mother's Na	me (First, Middl	e, Maiden	Sumame)	
ā		To B	HERBERT WILLIAMS						ANNETT	E CAWLE	Y		
Maryland	s 1 and 2 should I Heatth and Men Item 27 is marke other traumatic	2	19a. Informant's Name/Relationship (T				_					or Town, State, Z	_
	1 and 2 Health Iem 27 I		CAROLYN LEBORYS	DAUGI	100				EAF ROA				
altimore,	of Hea of Hea f Item		20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place ceme	of Dispo etery, crer	sition (Name natory or c	me of other place	. 1	Date	20c. Lo	ocation - City or	Town, State
Ĕ	Pages ment of I ant: If Its ury or o		*4 □ Donation 5 □ Other (Specify		MOREL					4/2004		LENDALE	
Balt	permit. Pages Department of Important: If It any Injury or o		21. Signature of Funeral Service Licen:	N. Va	nlo-				s of Facility T				HOME, P.A. 1286
b			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that cause one cause on each li	ne.			_ ,		c or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. HC	ule		Tro	ORE	2				Days.
	/Medical Examiner		1	Due to (or as	a consequent	ce of):							/
		<u>~</u>	Sequentially list conditions,	b. Dua to (or as	a consequent	na oth:							
5	red nsit	i	if any, loading to immediate cause. Enter Underlying Cause (Disease or injury										
	al-tra	Examiner	that initiated events resulting in death) Last	Due to (or as	a consequent	ce of):							
8760	icate be executed physicien and the burial-transit	dicail		d									
9		a)											
Вох	seath certific attending p	S	23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth		ath 3.「	Ectopic p	regnancy				23d. Date of del	
a.	Physician: The law requires that the death certif this certificate has been signed by the attending ral director, page 2 should be detached for use a	Physician/M	in the past 12 months? 1 🗆 Yes 2 Di No	4☐ Pregnant a			Other (s					Month	Day Year
P.O.	by the	h	9 Unknown										Mark and the state of
Ś	es thi	by F	Part II. Other significant conditions of	-		g in the u	nderlying (cause give	en in Part I.				the cause of death?
ğ	w require been si should I		- PAEU	MONI	A:					1	Yes 2	□No 3□Pr	obably 4 Unknown
Vital Record	e taw r has be je 2 sh	ple									opsy	prior to	topsy findings available completion of cause of
<u> </u>	The ate h page	Completed								per 1 ☐ Yes	formed? 2 Who	death?	2 No
ita	ysician: The Instruction of Security of Security (1986) is director, page	Be (25. Was case referred to medical examiner?					0.1	4-7-5	eath (Check only	one)		
Ž	hysic his co	2	1 ☐ Yes 2 No	Hospital: 1 Inpati			-	_	4 Xinursing			6 Other (Spec	cify)
0	ding Phy th. After thi funeral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju	ay Year) 28	b. Time o Injury		28c. Injun Worl	?	28d. Describe	how inju	iry occurred	
sio	Attending or death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be				М		Yes 2 □ No	00/ 1	/21	- 140	
Division of	d or Att	Certification;	4 Homicide determined	280. Flace of III	tc. (Specify)	, fam, st	reet, factor	y, office			(Street all own, State		ural Route Number,
	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a, Certifier 1 Certifying Ph	ysician: To the best	of my knowle	dae dest	h occurred	at the tim	ne date and nise	e, and due to th	e caneale	and manner as	s stated.
	Hos 24 ho Fund fely f	edical	(Check only 2 Medical Exam	ysician: 10 the basis of and manner st	of examination	and/or in	vestigation	n, in my o	pinion, death occ	curred at the time	o, date an	d place, and due	to the cause(s)
	To the within 2 To the I	Med	29b. Signature and tittle of certifier	// /			29	c. License	e number		29d. Da	ite signed (Monti	h. Day, Year)
)	F 3 F 0		MATHOR	allen			53.	D-1	12840	3	,	1-11-0	04
	V		30. Name and address of person who	completed cause of	death (Item 23	la) (Type							
	\		AH (SHII AD)	1.MD.	760		05	LE	RDY	. You.	SOM	MI	21204
	St	ate	31. Date filed (Month, Day, Year)	32. Regist	rar's Signature		,						
	Regist		IAN 1 9 200A	Fre Leve	and a	14	2 - 1	1000	yp*				

Schineider, Maurice Henry Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

			Type or Print i State of Mary							_	
		1 - For State Registrar	•			tificate of			Reg. No.		1 2 4 1
		Decedent's Name (First, Middle, La.	st)					2. Date of De	eath Day	Yeer	3. Time of Death
Physici		MAURICE	H. Sch	neipe	2R			Tanua	,	10,2004	2:05 PM
/Medic Examin		4a. Facility Name (If not institution, giv	street and number)			4b. City, Town, o	r Location of Deat	h	-	County of Deeth	
		Franklin Squa	ire Hospit	al G	nter	Rose				altimo	
Funeral Director		213-34-549/	THE OF /	yrs. last b	irthday) Yrş.	Months Days	Hours Min.			Coun	lace (State or Foreign try)
D .		Usual Residence of Decedent 10a. State 10b. County	10	c. City, To	wn or Lor	ation		•		1	0d. Inside City Limits
aryla •ho	ō			o. o., , , , ,		Gewon	D'				1 Yes 2 No
the M	Director	10e. Street and Number	RFORD		L- 4	10f. Zip Code	-		10a. Citi	zen of What Coun	itry?
death with the Maryland ims 23s or 28s-f ehow ims 15s nullified at		1620 SWAL	low Cre	CT T	DR		21040			U.S. F	
eath	Funeral	11. Marital Status	12. Was Decedent Ever				lispanic Origin? (S an, Mexican, Puer	pecify Yes or No	0-	14. Race - Americ	an Indian,
fler dea	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No					to Rican, etc.)		Black, White,	etc.
hours after tural', or ite	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1	☐ Yes 2☐ No	Specify:			Specify: W	nite
72 hours	Completed	15. Decedent's E	ducation	16	a. Deced	ent's Usual Occup	ation during most of wo	rkina	16b. Ki	nd of Business/Inc	iustry
	npie	Elementary/Secondary (0-12)	College (1-4or 5+)		life. E	O NOT use retired	d)	9			
filed within Hygiene. Ither then	Con	13+1	NIA		7	rechani					ORP.
be filed tal Hyg of othe	Be	17. Father's Name (First, Middle, Last	. ^				0	me (First, Middle			
	2	John Schne					Cather			vreich	
d 2 should th and Mer 7 is marke traumatic		19a. Informant's Name/Relationship (and Number or Re				21040
and lealth m 27		Diane Tingl			o (8	多し合しのい ition (Name of	s crest	Date		cation - City or To	
Pages 1 and 2 nent of Health and: If item 27 int: If item 27 inty or other tra		20a. Method of Disposition Burial 2 Cremation 3	Removal from State	cemet	өгу, сгөп	atory or other place			-		
. Pa tmen tant: jury		4 Donation 5 Other (Special		Moed		n cem	. , .	1104	200	Ito. MO	
permit. Page Department of Important: If any injury or		21. Signature of Funeral Service Lice	S+01		H	ARTICY M	iller - 5	Tella Fu	nero	1 Home	CH1).
4 40540		23a. Party. Enter the disease, or com	July-	doeth Do	1.7.5	77 has	ord RD.	Balto	Mo.	21334	Approximate
		shock, or heart failure. List only	one cause on each line.					,			Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	. Acute			urdial	infar	ction			
/Medical Examiner		1	Due to (or as a co	nsequence	a of):	مناجم		-0.511	die	0000	
	<u></u>	Sequentially list conditions, if any, leading to immediate	b. Chronic	nsequence	OTY(ICTIVE.	pumo	nary	013	EUZE	
ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury			,						
executed n and ial-transit	xar	that initiated events resulting in death) Last	C. Due to (or as a co	nsequence	e of):						
3 4 = =		· ·	d								
ficate be physicials the bur	Physician/Medical		u								
death certifica attending ph	ZM	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p							23d. Date of delive	ory
atte	ciai	in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim			Ectopic pregnancy Other (specify) _	у			Month	Day Year
that the do	ysi	9 Unknown	9□ Unknown								
The law requires that the death certificate be see has been signed by the attending physicis page 2 should be detached for use as the but	by P	Part II. Other significant conditions	contributing to death but n	ot resulting	in the ur	derlying cause giv	ven in Part I.	23e. Did	tobacco u	ise contribute to th	ne cause of death?
quires n sign								1 🗆	Yes 2	No 3□ Prob	ably 4 Unknown
w requir	lete							24a. Wa		24b. Were auto	psy findings available
he lav e has	Completed							perf	ormed?	death?	mpletion of cause of
vician: Th	0	25. Was case referred to medical					26. Place of De	1 ☐ Yes ath (Check only	2 No	1 103	20110
Physician: r this certifica	0 8	examiner? 1 ☐ Yes 2 👿 No	Hospital: 1 X Inpatient	2 🗆 ER/0	Outpatien	3 DOA Oth	nan .			6 ☐Other (Specifi	v)
g Phys er this	1	27. Manner of Death	28a. Date of Injury (Month, Day Ye	28b	. Time of	28c. Inju		28d. Describe			
ath. r: After e funer	atlo	1 Natural 5 Pending 2 Accident investigation		,,	qu.y		Yes 2 □ No				
Arte er de ecto by th	lific	3 Suicide 6 Could not to determined		- At home,	farm, str	et, factory, office			(Street an	d Number or Rura	I Route Number,
s aft of or or or or or or or or or or or or or	Certification:			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						,	
To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edicai		hysicien: To the best of m miner: On the basis of ex-								
the thin 24 the F	ledi	one)	and manner stated								
To To con	Σ	29b. Signature and title of certifier	and a			29c. Licens	o iluitoai		/ / .	e signed (Month,	Jay, 1 odi)
,		MACINESI	$(m\rangle)$			Kes	UDDC)	1/10	104	
E		30. Name and address of person who	completed cause of death	(Item 23a			S	D	D	' /	MA 0
		Angelyn Kany 31. Date filed (Month, Day, Year)	32. Apgistrar's	Signature	1 tr	anklin c	guare.	Drive	CALIT	more, r	MD 21237
St Regist	ate rar		2004 Degus	K	A	and 9					
		SPAN - U C	A STATE OF THE STA	- 50	19						

DHMH 17 Rev 1/2001

PAYSIGN Medical Examiner 48 - Facility Name (if not institution, give street and number) 53 - Social Security Number 53 - Social Security Number 6 - Sex 77 - Yrs. 10 - Social Security Number 10 - Social Security			Registrar Decedent's Name (First, Middle, La			Cel	uncale	OIL	Jeaui		2. Date of Dea	th		3. Time of Death
as Facility have of orientations on the amend and number) as South 3 Sectory Warmer as South 3 Sectory Sectory as Sectory Warmer as South 3 Sectory Warmer as South 3 Sectory Sectory as Sectory as Sectory					K									
212-22-4441 Date Treatment of December Date			4a. Facility Name (If not institution, giv	e street and number)	ter	4b. City, T	Town, or	4				ounty of Death	_1
Section Sect			212-22-4441		ge (In yrs.						(Month, Day	Year)		
Section Sect	A H				10c. Cit	y, Town or Lo	ocation				-		1	10d. Inside City Lim
Section Sect	불	ţ	MD BALTIN	10RE	LC	CH RAV	EN HE	IGHT	rs					1 Yes 2 🔀
STATE (RADE HOMEMAKER 15. Mother's Name First, Middle, Makides Sumame) 16. Mother's Name First, Middle, Makides Sumame) 17. Farster Name First, Middle, Makides Sumame) 18. Mother's Name First, Middle, Makides Sumame 18. Mother's Name First, Middle, Makides Sumame 18. Mother's Name First, Middle, Makides Sumame 18. Mother's Name First, Middle, Makides Sumame 18. Mother's Name First, Middle, Makides Sumame 18. Mother's Name First, Middle, Makides Sumame 18. Mother's Name First, Middle, Makides Sumame 18. Mother's Name First, Middle, Makides Sumame 18. Mother's Name 18. Mother'	or 28e	irec	10e. Street and Number				10f. Zip (Code			1	0g. Citize	on of What Cou	ntry?
STATE (RADE HOMEMAKER 15. Mother's Name) (First, Middle, Last) 15. Mother's Name) (First, Middle, Last) 15. Mother's Name) (First, Middle, Last) 15. Mother's Name) (First, Middle, Last) 15. Mother's Name) (First, Middle, Last) 15. Mother's Name) (First, Middle, Last) 15. Mother's Name) (First, Middle, Last) 15. Mother's Name) (First, Middle, Makisan Surmane) 15. Mother's Name) (First, Middle, Makisan Surmane) 15. Mother's Name) (First, Middle, Makisan Surmane) 15. Mother's Name	23a		1826 BRIARCLIFF	ROAD				2123	34			US	5A	
Security Control Con	al', or Itams Examiner m	þ	1 Never Married 2 Married	Armed Forces 1 Tyes 2 X	? No		If Yes, speci	ify Cuba	n, Mexican	gin? (Spe i, Puerto l	ecify Yes or No- Rican, etc.)		Black, White,	etc.
Southern State Continue C	natur	eted			-	(Give	kind of worl	k done d	luring most	t of workii	ng	16b. Kind	of Business/In	ndustry
17. Farber's Name (First, Middle, Last) 19b. Mailing Address (Street and Number of Rural Route Number. City or Town. State, Zig Code) 19b. Mailing Address (Street and Number of Rural Route Number. City or Town. State, Zig Code) 19b. Mailing Address (Street and Number of Rural Route Number. City or Town. State, Zig Code) 19b. Mailing Address (Street and Number of Rural Route Number. City or Town. State, Zig Code) 19b. Mailing Address (Street and Number of Rural Route Number. City or Town. State, Zig Code) 19b. Mailing Address (Street and Number of Rural Route Number. City or Town. State, Zig Code) 19b. Mailing Address (Street and Number of Rural Route Number. City or Town. State, Zig Code) 19b. Mailing Address (Street and Number of Rural Route Number. City or Town. State, Zig Code) 19b. Mailing Address (Street and Number of Rural Route Number. City or Town. State, Zig Code) 19b. Mailing Address (Street and Number of Rural Route Number. City or Town. State, Zig Code) 19b. Mailing Address (Street and Number of Rural Route Number. City or Town. State, Zig Code) 19b. Mailing Address (Street and Number of Rural Route Number. City or Town. State, Zig Code) 19b. Mailing Address (Street and Number of Rural Route Number. City or Town. State, Zig Code) 19b. Mailing Address (Street and Number of Rural Route Number. City or Town. State, Zig Code) 19b. Mailing Address (Street and Number of Rural Route Number. City or Town. State, Zig Code) 19b. Mailing Address (Street and Number of Rural Route Number. City or Town. State, Zig Code) 19b. Mailing Address (Street and Number of Rural Route Number. City or Town. State, Zig Code) 19b. Mailing Address (Street and Number of Rural Route Number. City or Town. State, Zig Code) 19b. Mailing Address (Street and Number of Rural Route Number. City or Town. State, Zig Code) 19b. Mailing Address (Street and Number of Rural Route Number. City or Town. State, Zig Code, Zig Code, Zig Code, Zig Code, Zig Code, Zig Code, Zig Code, Zig Code, Zig Code, Zig	Tria Mg	omp		College (1-4or	5+))			OW	N HOME	
19b. Mailing Address (Srees and Number or Rural Route Number. City or Town, State, 2p Code) ALBERT SVRJCEK SON 1204 CONSTANTINE COURT BEL AIR, MD 21014 20b. Menod of Disposition Will Brish 2 (Closation - City or Town, State) ALBERT SVRJCEK SON 1204 Place of Disposition (Albert) 20b. Menod of Disposition On Date 2 (Closation - City or Town, State) ALBERT SVRJCEK SON 1204 Place of Disposition (Albert) 20b. Menod of Disposition City or Town, State 2 (Closation - City or Town, State) MORELAND MEM. PARK 1/12/2004 HILLENDALE, MD 21 Signature of Funanti Service Licensey 22 Name and Address of Recity THE JOHNSON FUNERAL HOME, P. A. ACCOUNTAGE AND MEM. PARK 1/12/2004 HILLENDALE, MD 23a. Parti. Einther the disease, or complications happleseport the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Accountage in the disease, or complications happleseport the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Accountage and the death of the disease, or complications happleseport the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Accountage of the disease or orificial resulting in death) 23c. If yes, outcome of pregnancy 1 (Library in death) Last originate as consequence of): 23c. Due to (or as a	D A	Be)		,						Maiden S	umame)	
Solid Soli	ls ma euma		19a. Informant's Name/Relationship	Type, Print)		19b. Mailir	ng Address	(Street a	and Numbe	or Or Rura	I Route Number	, City or 1	Town, State, Zip	o Code)
A Donation 3 Demonstration 3 Demon	m 27 har tr			SON		and the same of th								
Solidar Soli			X☐ Buriai 2 ☐ Cremation 3 ☐		3				1					
Sician Part Enter the disease, or complications that/sused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one curse in each line. Approximate shock, or heart failure. List only one curse in each line. Approximate shock, or heart failure. List only one curse in each line. Approximate shock, or heart failure. List only one curse in each line. Approximate shock or respiratory arrest. Approximate shock, or heart failure. List only one curse in each line. Approximate shock or respiratory arrest. Approximate shock or respir	njury				MOF									
23a. Part I. Enter the disease, or complications that/equived the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate considering in the interest of the construction o	eny i		Post Asserted Lice	1///										0.21
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	miner		Sequentially list conditions, if any, leading to immediate cause. Ener Underlying Cause (Disease or injury that initiated events	b. Due to (or a Due to (or a c.	s a conseq FLE s a conseq	MYELO uence of):	MA							
1 Yes 2 No 3 Probably 4 Unk	attending l for use as	ysician/Med	23b. Was decedent pregnant in the past 12 months? 1 🗆 Yes 2 📉 No	1□Live birth 4□Pregnant	2 Feta	I death 3						23		,
Second S	gned eb ec	b	Part II. Other significant conditions	contributing to death	but not res	ulting in the u	nderlying ca	ause give	en in Part I.		111			
27. Manner of Death 1	ate has page 2	Complete									autops perfor	ned?	prior to co death?	impletion of cause
determined 286. Place of injury - At nome, farm, street, factory, office 287. Location (Street and Number or Hural Houte Number of	rector	00	examiner?	Hospital:				Othe	25.					
determined 286. Place of Injury - At nome, farm, street, factory, office 287. City or Town, State) 288. Place of Injury - At nome, farm, street, factory, office City or Town, State) 289. Coation (Street and Number or Hural Houte Number City or Town, State) 291. Coation (Street and Number or Hural Houte Number City or Town, State) 292. Certifier (Check only one) 293. Certifier (Check only one) 294. Date signed (Month, Day, Year) 295. Signature and title of certifier 296. Date signed (Month, Day, Year)	r this oral di	\vdash		1 Arinpai				A	4 U Nu	-				(y)
286. Place of Injury: At nome, farm, street, factory, office 287. Cation (Street and Number or Hural Houte Number of Hural Houte Nu	Afte fune	tion			ay Year)									
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	Direc	Certifica	3 Suicide 6 Could not b	289. Place of II	njury - At h etc. <i>(Specii</i>	ome, farm, sti (y)	reet, factory,	, office		2			Number or Rura	al Route Number,
D Dan Cl D 30263 01-09-04	a Funeri		(Check only 2 Medical Exa	miner: On the basis	of examina	owledge, deat ation and/or in	h occurred a vestigation,	at the tim	e, date an	d place, a th occurre	and due to the c ed at the time, d	ause(s) ar ate and p	nd manner as s lace, and due to	stated. the cause(s)
D 20263 01-09-04	To th	Me	29b. Signature and title of certifier			-3	29c.	License	number		2	9d. Date	signed (Month,	Day, Year)
		}	non	n	0	//	I	30	0263			(01-09	-04
			2		death (Iter	n 22a) (Tuna	Print)							

			1 - For State TAPEND II	EM 18 PE								Mental Hy	gien Reg. N	scon had but	f	CUTUL
	Dhusisi		1. Decedent's Name (First	, Middle, Last)					~			2. Date of De	aath Da	av Y	ear	3. Time of Death
	Physici: /Medic		DONALD D	•		S	EIDMAN					January	8	200		6:15 PM
\$e	Examin	er	4a. Fecility Name (If not in	stitution, give	street and numb	er)		-	y, Town, o	hor	on of Deat		N/	County of	Death	
i	Funeral Director		5. Social Security Number 197–18–219		M 2□F	Age (In yrs.	last birthday) Yrs.	If Und Month	ler 1 Year	If Un Hou	der 24 Hrs.	8. Date of Bir MAR 1	rth av, Year	928 P	Cour	lace (State or Foreign ttry)
	and w		Usual Residence of Deced	dent County		10c. Ci	ty, Town or Lo	cation							1	0d. Inside City Limits
	f aho	or		TIMORE			TIMORE									1 ☐ Yes 2 Y No
	1 the 7 288-	rect	10e. Street and Number			1		10f. 2	ip Code				10g. C	itizen of Wha	at Coun	ntry?
	h with	al D	2212 OXEYE	ROAD				2	1209				USA	·		
2-003p	72 hours after death with the Maryland tratural; or Items 23s or 28s-t show creat Estanting found by notitied at	by Funeral Director	11. Marital Status 1 Never Married 2 3 Widowed 4 Di	Married	12. Was Decede Armed Force 1 (1) Yes 2 If Yes, Give Year or Date	os? □NoAIR			edent of Hoecify Cuba 2 No	ispanic in, Mex Spec		pecify Yes or No o Rican, etc.)	0-	14. Race - Black, Specify:	White,	etc.
ک د	72 nat	eted		ecedent's Edu			16a. Dece	dent's Us	ual Occup	ation	nost of wo	rkina	16b. l	Kind of Busin	ess/Ind	dustry
1717	within	Completed	Elementary/Secondary		College (1-4	or 5+)	SALESI	DO NOT	use retired	1)	.,		HAR	DWARE		
yland	uld be filed fental Hygid rked other tic event,	To Be (17. Father's Name (First, I LOUIS	Middle, Last)		SE	I DMAN			18. M	CIE	ne <i>(First, Middl</i> e FLIA		n Sumame) SNER		
Mar	end 2 should eatth and Men n 27 is marke ier traumatic		19a. Informant's Name/Re MRS.ARLENE S					-				ORE, MD.			ite, Zip	Code)
<u>ő</u>	- T 5 =		20a. Method of Disposition			20b.	Place of Dispo	sition (A	ame of	e)		Date	20c. L	ocation - Cit	y or To	wn, State
Ĕ	Peges ment of l ant: If its ury or o		1 🛱 Burial 2 □ Cren 1 □ Donation 5 □ O		emoval from Sta	th CH	AIM) C				1	11,2004			-	
Baltimore,	permit. Peges Department of I Important: If ite any injury or of once.		21. Signature of Funeral S	Service License	· ·							L LEVIN ROAD PI				
			23a. Part / Enter the dise shock, or heart failur	ase, or compli	cations that cau le cause on eac	sed the dea h line.	th. Do not ent	er the m	ode of dyin	g, such	as cardiad	or respiratory a	rrest,			Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)		mete	stet	is re	mal	Ce	11-	CRI	cinama				1 egys
	/Medical Examiner		resulting in death)		Due to (or	as a consec	quence of):								1	
	P ii	Iner	Sequentially list conditions if any, leading to immedia cause. Enter Underlying Cause (Disease or injury	s, to		as a consec	quence of):									
ວົ	icate be executed physicien and s the burial-transit	Examiner	that initiated events resulting in death) Last		Due to (or	as a consec	quence of):									
8/PD	cate be	edical			l										-	
Q Q Q	death certifie e attending p id for use as	ı/Me	IF FEMALE: 23b. Was decedent pregn	ant 2	3c. If yes, outco									23d. Date o	f delive	īv
Ö.		Physiclan/M	in the past 12 month 1 Yes 2 No 9 Unknown		1□Live birth 4□Pregnan 9□Unknow	t at time of o			pregnancy specify)					Month		Day Year
1	law requires that the as been signed by the 2 should be detache	by Ph	Part II. Other significant of	onditions cor	tributing to deat	h but not res	sulting in the u	nderlying	cause give	en in Pa	art I.	23e. Did t	obacco	use contribu	te to th	e cause of death?
cords,	w require been sig should b	edt	Coronary	crter	y dis	esse						10	Yes 2	□No 3[Prob	ably 4 Dunknown
a)	as be	Completed										24a. Was		24b. Wer	e autop	psy findings available inpletion of cause of
<u> </u>	The law cate has	Соп		_								perfo 1 ☐ Yes	2 No	dea	th?	22 No
Упа	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to examiner?		ospital:				Oth	200		th (Check only o				
ō	Phys r this ral dii	: To	1 Yes 2 No		28a. Date of	Injury	ER/Outpatien		JUA	4 _	Nursing H	ome 5 Resi			Specify	′)
0	nding ith. :: Afte e fune	atlor	1 Natural 5 ☐ 2 ☐ Accident	Pending investigation	(Month,	Day Year)	Injury	М	28c. Injun Work	<7 Yes 2	No			,		
DIVISION	To the Hospital or Attending Physician: within 24 hours after deals To the Funerel Director: After this certific completely filled in by the funeral director,	Certification;		Could not be determined	28e. Place of building	Injury - At h , etc. (Speci	ome, farm, str fy)	eet, facto	ory, office			28f. Location (City or To			or Rura	l Route Number,
	Mospite 24 hours Funere etely fille	edical C	29a. Certifier 12°C (Check only one)	ertifying Phys ledical Exemin	sician: To the be ner: On the basi and manner	s of examina	owledge, death ation and/or in	occurre estigation	d at the time	ne, date pinion,	and place death occu	, and due to the rred at the time,	cause(s date an	and manne d place, and	or as st	ated. the cause(s)
	To th within To th compl	Me	29b. Signature and title of	certifier				2	9c. License	numb	er		29d. Da	ite signed (A	fonth, L	Dey, Year)
	1		CAATT	MO				6	205-	- 0	00		Jens.	~ ×	. 7	200
	X		30. Name and address of			of death (Ite		Print)	-					1 0	1	
			31. Date filed (Month, Day		1brech	istrar's Sign	MC		Since	, 1	dee ,	del et	-	Bathr	201	٠
18	Sta Registr			3 2004	SZ. FIEG	ionai s olym	Asse	KI								

			For AMEND ITEM #19at	State of I	Marylan G827 1,	d / Depa /13/04.e/	artmer H <i>Tificat</i>	nt of He te of D	ealth an <i>eath</i>	d Mei	ntal Hygie	ene 1. No.		00563
	Age.		1. Decedent's Name (First, Middle, Las	t)							Date of Death Month		Year	3. Time of Death
	Physicia /Medic		JOSEPHINE	Н.	SAN	TONI				J	ANUARY	Day 12 20		6:35 A M
	Examin		4a. Fecility Name (If not institution, give			177	,		ocation of D			4c. Count		DEI CO
			GENESIS ELDERCA 5. Social Security Number 6. Se			IX (last birthday)			A PARK		Date of Birth			NDEL CO.
	Funeral Director			□M 217 F	84	Yrs.	Months	Days	Hours N	Min.	(Month, Day,) [av 03]			plece (Stete or Foreign ntry) Ware
	و ي		Usual Residence of Decedent		toc Cit	v. Town or Lo	cation							10d. Inside City Limits
	shov	5	10a. State 10b. County Md. Anne Art	undel Co		Pasad								1 ☐ Yes 2 🎇 No
	the M	Director	10e. Street and Number					p Code			109	g. Citizen of	What Cou	ntry?
	h with		7809 Leonardo C	ourt					21122	2		U.S	.A.	
	ems ?	Funerai	11. Marital Status	12. Was Decede Armed Force	es?	.S. 13.	Was Dece	dent of His	panic Origin , Mexican, P	? (Specification Rice)	y Yes or No- an, etc.)		ce - Ameri ck, White,	can Indian, etc.
20	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ ∭Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Date			1 🗆 Yes	2 X No	Specify:			Speci	⁄y: whi	ite
5	72 hours after death with the Maryland natural: or Items 23a or 28a-f show disal Examinas must se notified at		15. Decedent's Ed	lucation		16a. Dece					10	6b. Kind of E	Business/Ir	ndustry
ב	b. B. Medi	Completed	(Specify only highest gra	de completed) College (1-4	or 5+)	life.	DO NOT I	use retired)	ring most of	working				
7	ygien ygien her th	Con	12	0		Hom	emak	1	I Mothor's	Namo /F	irst, Middle, Ma		ome	
	ntal Hed oth	Be	17. Father's Name (First, Middle, Last) Oscar L. Ho	ewitt						Lly I		ennis		
	should nd Me mark matic	ို	19a Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Addres	s (Street ar						o Code)
Z	alth ar 27 is		ALESSANDRA SANTON	G CAUGHTE	R) ghter)	7809	LE 5	HOLLAN	Cytii t	SAL SE	oute Number, IRY MD Sadena,	Md.	21122	2
o e	of He of He item		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from St	1 .	Place of Dispo cemetery, crer	sition (Na matory or	me of other place	01	Date /13/		c. Location	- City or T	own, State
agrim	Pag tment tent: I		* 4 □ Donation 5 □ Other (Specifi	y)	Ba	yview			1					re, Md.
n n	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: If item 27 Is marked other than "natural" or Items 23a or 28e-f show eny injury or other traumatic event, I'm Medical Examinating must be notified at QDCs.		21. Signature of Funeral Service Licen		0922	22	2. Name a M 3	cCull 204 M	y-Poly ountai	niak in Ro	Funera	1 Hom sadena	e P.A.	21122
20			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cau	ised the deat th line.	th. Do not ent	ter the mo	de of dying	such as car	rdiac or re	espiratory arres	it,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Se	PS1.									days
	Examiner			Due to (or	ås a consec	quence of):								
	ig Bu	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consec	luence of):								
	ecuted ind transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c										
60,	icate be executed physician and s the burial-transil	al Ex	resulting in doutry East	DU0 10 (0)	as a consec	querica or).								
09/89	ficate physics the	edical	" >	d										
XOR	leath certific attending p	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregna	ancy	TEctopic (pregnancy					ate of deliv	,
	The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months? 1 🗆 Yes 2 🗓 No		nt at time of o		Other (s					М	onth	Day Year
л О	res that the de signed by the a l be detached f		9 ☐ Unknown Part II. Other significant conditions of	contributing to dea	th but not res	sulting in the u	ınderlyina	cause give	n in Part I.		23e. Did toba	cco use cor	ntribute to	the cause of death?
Vital Records,	signe	d by	Parinheral	Vasa	ulai		ise	150			1 ☐ Yes	2 🗆 No	3 🗌 Pro	bably 4 Dunknown
CO	w require been si should b	lete									24a. Was an	24b.	Were aut	opsy findings available ompletion of cause of
Ř	The ta te has age 2	Completed									autopsy perform 1 Yes 2	d?	deeth?	2D No
ā		BeC	25. Was case referred to medical examiner?							f Death (C	Check only one			
	Physician: The lav this certificate has al director, page 2	ဂ္	1 □ Yes 2 □ No			ER/Outpatier			4 Mursi		5 Residen			fy)
no	ding F h. After funera	tion:	27. Manner of Death 1. Matural 5 Pending 2. Accident investigatio		Day Yeer)	Injury	" м	28c. Injury Work	at ? es 2⊡No		d. Describe hov	r injury occu	1190	
Division of	or Attending Physician: after death. Director: After this certifica in by the funeral director, I	fica	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place o	f Injury - At h	lome, farm, st	reet, facto	ry, office		28f	. Location (Stre		ber or Rur	al Route Number,
ā	urs afte ral Dir	Certification;												
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral	edical	29a. Certifier 1 Certifying Pl (Check only 2 Medical Example)		is of examina									
	To th withir To th comp	Me	29b. Signature and title of certifier	4 . 0			2:	9c. License	number	25	29	d. Date sign	ed (Month	Dey, Year)
1			- Mr.	M		- 0011)		100	010	N)	/	-10	1 - 0	x00 9
	4		30. Name and address of person who	GON	5601	Veter	Print)	Hwy	M.C	ler	sville	M	10	21/08
	Sta Regist		31. Date filed (Month, Day, Year)	104 32 Ae	gistrar's Sign	ature H		. 0						

DHMH 17 Rev 1/2001

ORIGINAL

			1 = For State Registrar	State	of Marylar	-	artment of <i>rtificate o</i>	Health and f Death	Mental Hy	giene Reg. No.		,
	Physic		Decedent's Name (First, Mid	die, Last) FRIEDA	· · · · · · · · · · · · · · · · · · ·		SELIGMA	NN	2. Date of De Month JANUAR	Day	Year	3. Time of Death 2:15 A M
	/Medi Examir		4a. Fecility Name (If not instituti		number)			, or Location of De			nty of Death	Z.13 A
			MANOR CARE -	- DULANEY				TOWSO	N		BAL.	TIMORE
	Funeral Director		5. Social Security Number 218-74-1742	6. Sex 1 ☐ M 2 ☐ A	7. Age (In yrs.	last birthday) 4 Yrs.	If Under 1 Yes Months Day			0 1909		place (State or Foreign
	and *		Usual Residence of Decedent 10a. State 10b. Count	v	10c. Cit	ty, Town or Lo	cation				1,	Od. Inside City Limits
	Marylan fed at	ro	MD N/A	•	BAL	TIMORE						1)∑Yes 2 □ No
	death with the Maryland ms 23a or 28a-f show Firstal be restined at	Direc	10e. Street and Number 7218 PARK HEIG	HTS AVE #	[‡] 203		10f. Zip Code 2120	8		10g. Citizen o	of What Cour	ntry?
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. important: If item 27 is marked other than "natural; or items 2: any injury or other traumatic svent, If a Medical Exactly of name 2000.	d by Funeral Director	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	urried Armed	Decedent Ever in U I Forces? es 2 Who Give X or Dates:		Was Decedent of Yes, specify C	f Hispanic Origin? luban, Mexican, Pue	(Specify Yes or No erto Rican, etc.)	14. R B	ace - Americ lack, White, cify: WHI	etc.
21215-(within 72 h ane. than "natu	Completed		est grade complete	e (1-4or 5+)	(Give	dent's Usual Occ kind of work don DO NOT use reti CHANT	e during most of w	orking	16b. Kind of		dustry
	filed Hygie other	e Co	17. Father's Name (First, Middle	, Last)				18. Mother's N	ame (First, Middle,			
ılan	ould be Mental arked atic sv	To Be	LOUIS	W(DLLACH			MINNIE		RANDE	EL	
Maryland	2 short and h		19a. Informant's Name/Relation		IOUTER	1	-	et and Number or F				,
	es 1 and of Health f item 27 r other t		MRS. ELLEN SCHO 20a. Method of Disposition 1 □XBurial 2 □ Cremation		20b. F	Place of Dispo	EW MARK sition (Name of OHY CONG	ESPLANAD	Date	LLE, ML 20c. Location WOODLAW	n - City or To	
Baltimore,	permit. Pag Department Important: I any injury o		'4 Donation 5 Other	Specify)	JIII State DL 1		. Name and Add		SOL LEVIN			TNC
ã	Depariment of the pariment of		- dry	mison	\		3900 REI	STERSTOW	N ROAD -	PIKESV		MD 21208
	Physician		23a. Part1. Enter the lise see shock, or hear failure. Lise Immediate Cause (Final disease or condition	or complications the st only one cause of		h. Do not ent	er the mode of d	ying, such as cardi FAILURE	ac or respiratory a	rest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due	to (or as a conseq AI 7I		DEMENT	TA AT				
	ted	nlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due	to (or as a conseq							
60,	ficate be executed physician and is the burial-transit	edical Examiner	that initiated events resulting in death) Last	c	to (or as a conseq	uence of):						
68760,	ficate I physics the t	odle		d								
P.O. Box	The law requires that the death certifi ate has been signed by the attending bage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Liv 4□Pri	outcome of pregnate birth 2 ☐ Fete egnant at time of disknown	Ideath 3□	Ectopic pregnar Other (specify)				ate of delive	r y Day Year
	uires that signed b ld be deta	by	Part II. Other significant condit	ions contributing to	death but not res	ulting in the ur	derlying cause (given in Part I.		obacco use co		e cause of death?
of Vital Records,	The law requir te has been si age 2 should	Completed							24a. Was autop perfo	med?	prior to con death?	osy findings available inpletion of cause of
ital		BeC	25. Was case referred to medic examiner?	ai				26. Place of De	1 ☐ Yes eath Check only o		1 🗌 Yes	2L No
∑ V	Physician: this certific ral director,	To	1 ☐ Yes 2 💢 No	Hospital:	☐ Inpatient 2 ☐	ER/Outpatien	0 00,11		Home 5 ☐ Resid	ence 6 🗆 O	ther (Specify)
on o	ding	tlon:	27. Manner of Death 1 XNatural 5 ☐ Pend 2 ☐ Accident inves	/8.4	ite of Injury Ionth, Day Yeer)	28b. Time of Injury	28c. in W M 1	ury at ork? □Yes 2□No	28d. Describe h	ow injury occu	irred	
Division	il or Attendi after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could	not be 28e. Pla	ace of Injury - At ho Ilding, etc. (Specify	ome, farm, stre			28f. Location (S City or Tow		ber or Rura	Route Number,
Ł	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifyi (Check only one) 2 Medica	ing Physician: To I Examiner: On the and m	the best of my kno basis of examina anner stated.	wledge, death tion and/or inv	occurred at the estigation, in my	time, date and place opinion, death occ	e, and due to the curred at the time, o	ause(s) and materials	nanner as sta , and due to	ated. the cause(s)
	To th withir To th comp	M	29b. Signature and title of certifi				29c. Lice	nse number		29d. Date sign	ed (Month, L	Dey, Year)
	1		> nathe		asa			0054970		JANU	ARY 8,	2004
	`		30. Name and address of person KATHERINE AS	SADI	76	500 OSL	ER DRIV	E #205	TOWS	ON, MD	21204	
	Sta Registr		31. Date filed (Month, Day, Year	2004	Registrar's Signa	ture	R)					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day 1 January 2, 2004 Year **Physician** 6:30 PM M Paul Spadone Jr /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Gilchrist Center Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months Days Hours Min. (Month, Day, Yeer) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 X M 2 ☐ F 73 Sept 15, 1930 131-26-6157 New York Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State Pages 1 and 2 should be filed within 72 hours after death with the Marylan enen of Health and Mental Hygiene, and it item 23a or 28a-f show and it item 27 is marked other than "natural", or itema 23a or 28a-f show and it item Mary or other traumatic event, the Marylace Exations at matter notified at any or other traumatic event, the Marylace Exations ty Yes 2 □ No MD Baltimore Owings Mills Direct 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 319 Golf Course Road 21117 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 153-63 Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) real estate 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Wilma Bartels Paul Spadone Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 319 Golf Course Road Owings Mills, Md Laura Spadone/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of important: If any injury or once: 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Wade 22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201 655 W. Baltimore Street Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Mesomeliona Immediate Cause (Final Dub to (or as a consequence of) RACI **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Examiner burial-transit The law requires that the death certificete be executed Due to (or as a consequence of): use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 2 Fetal death 3 Ectopic pregnancy 1☐Live birth Year 0 Month Day 4 Pregnant at time of death 5 Other (specify) signed by the air d be detached fo 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No should been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? res 2.20No has certificate 1 ☐ Yes To the Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) TOSPICE 2 No 1 🗌 Inpatient 2 ER/Outpatient 3□ DOA ၉ 1 Tes this To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Medical Certification: Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after Example 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 24 within 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 58303 WO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St Bultonin MO 6601 Large 105 Maron J. 31. Date liled (Month, Day, Year) 32. Registrar's Signature State 1 3 2004

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

m 2 2004

Division of Vital Records, P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 8:35AM **Physician** THOMAS 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner MEADOUN der 1 Year | If Under 24 Hrs. BAL TILLORE Ketik Mest Center 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Min 1 □ M 2 1 95 MARY/AND 9321 Director 12/01 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23e or 28e-f show any injury or other traumatic event, it a Medical Examination results once. 1 Yes 2 No BAIT HORE G/EN RALY 1420 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 2/057-9403 11630 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Black, White, etc Never Married 2 Married 1□ Yes 2 → No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) State HUMAN Kelation Coltege (1-4or 5+) Elementary/Secondary (0-12) Comprission) Adam Wistative 4 EARS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be THOMA 0 LAKENCE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print)/ 5507 Sowington RIAD BAIRMON Marylows Cousin AUGUS FUS E/125 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) U. A. Church Cometer HEYELOP 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility CHATHAR - NAKALI 21. Signature of Funerat Service Livensee Funcial None-5240 RETSTETShow LUNO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heary failure. List only one cause on each line. Approximate the thread Between Onset and Death Immediate Cause (Final disease or condition resulting in death) concer **Physician** /Medical Due to (or as consequence of Examiner Sequentially list conditions, Due to (or as a consequence of): Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last hysician and the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day Month Year in the past 12 months? for 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 3 Probably 4 Unknown 1∐ Yes 25√No cate has been signated to page 2 should to 24a. Was an autopsy performed? 1 ☐ Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After t 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. Director: / 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🔲 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours a To the Funeral D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 7,2004 und tho completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe M. Charles St. Balto. W-A. R. Lay 6701

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

Chunc

32. Registrar's Signature

		1 - For State Amend Item 1 p Registrar			Centifica	ite of L	Death		Reg. No.		
Dhusisi		1. Decedent's Name (First, Middle,	Whet f		pson aka Ro	bert L	. Thomas	2. Date of		Year	3. Time of Death
Physicia /Medic		ROBERT LO	UIS THO	mpse	7			John W	ary 1.	2004	(00P
Examin		4a. Fecility Name (If not institution,	a i	7)	4b. Cit	y, Town, or	Location of D	ath	√ 4c. €	ounty of Death	1
		Mountand	General	HÔS	DIAI B		nore			NIA	
Funeral			6. Şex 7. Ā 2 M 2 □ F	Age (In yrs. lad	It birthday) If Und Month	ler 1 Year s Days	If Under 24 h	in. 8. Date of (Month,	Day Yearl	COLL	place (State or Fore
Director	9	Usuel Residence of Decedent		65	Trs.			Ly	18/19.	38 N.C	mouna
* =		10a. State 10b. County	/	10c. City, 7	Town or Location						10d. Inside City Lim
t sh	ō	Harylow N	A	-	BALLA						180es 2 🗆
notified at	Director	10e. Street and Number	, ,			Zip Code			10g. Citize	n of What Cou	ntrv?
0 9		1423 Mca	11.1. 57	rect	1.52	210	2/7		log. Okico		, .
ns 23a	Funeral	11. Marital Status	12. Was Deceden	nt Ever in U.S.	13. Was Dec			(Specify Yes or	No- 14	. Race - Americ	can Indian
ritar Militar	F	1 Never Married Amarries	Armed Forces	37	If Yes, sp	ecify Cuba	n, Mexican, Pu	erto Rican, etc.)		Black, White,	
al', or	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates	:	1 Tes	21 No	Specify:		S	pecify B	lack
natural lical Ex	Completed	15. Decedent's	Education		16a. Decedent's Us				16b. Kind	of Business/In	
Marin .	ple	(Specify only highest Elementary/Secondary (0-12)	College (1-4o	(5+)	life. DO NOT	vork done d use retired	furing most of)	vorking			/
ar th	ь По	115 goods	Jones (1 40)		PAINTER	/			Self	, Empo	1400
oth o	Be (17. Father's Name (First, Middle, La	ast)				18. Mother's I	lame (First, Midd			
marked matic ev	To	Lloyd Coc	HRANNE				LULA	May	WIL	gate	
th and Mental Hygien 7 Is marked other thu traumatic event, Lin		19a. Informant's Name/Relationship	p (Type, Print)	0	19b. Mailing Addre	ss (Street a	and Number or	Rural Route Nur	nber, City or 7	own, State, Zip	Code) 2/2/
alth 127 I er tra		LOUVENIA 5.7	Homas 10	· efe	1423 N	no Cui	Jah S	Freet 1	BALTI	uore 1	Raky/no
of Healt litem 2 r other		20a. Method of Disposition		1 com	ce of Disposition (N	ame of other place	9)	Date /	20c. Loca	tion - City or To	own, State
	1	1 Burial 2 □ Cremation 3 14 □ Donation 5 □ Other (Spe		6	LION C	v .	·) /	17/04	Bolt	NUR 1	mare la
E E E .	1	21. Signature of Funeral Service Lin	consee	T.L.	22. Name	and Address	s of Facility	WA THE	2 - 1/	ARRII	Enerth
Empo Eny ir		Xun 16	50°		52 40	REIN	MOR I	on so	MB		
4 4		23a. Part1. Enter the disease, or co	omplications that cause	ed the death.	Do not enter the mi	ode of dying	g, such as card	iac or respiratory	arrest,		Approximate
ysician		shock, or fear failure. List or Immediate Cause (Final								1	Interval Between
Viedical -		disease or condition		1 0 1	0 1 0	nica	10000	110			Onset and Death
		resulting in death)		2 ATI		NEI	mon	IA			Onset and Death
aminer		Tesulting in death)	Due to (or a	s a consequer	nce of):						Onset and Death
\$.6	Jer.	Sequentially list conditions,	Due to (or a	s a consequer	nce of):						Onset and Death
100 mm / 100	ıminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a	s a consequer E L s a consequer	nce of):	316	EDIA	14	101cA1	LY DIR	
and I-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a Due to (or a CHA	s a consequer E L s a consequer	nce of): G / /: nce of): C CSS	316	EDIA	14	1012 A1	LY DIRE	
and I-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or a Due to (or a CHA	s a consequent as a consequent $0 \sim 10$	nce of): G / /: nce of): C CSS	316	EDIA	14	101 A1	LY DIR	
physician and s the burial-transit	edicai	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or a Due to (or a CHA	s a consequent as a consequent $0 \sim 10$	nce of): G / /: nce of): C CSS	316	EDIA	14	70121	ly DIC	
g physician and as the burial-transit	edicai	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a d.)	is a consequer S a consequer S a consequer S a consequer	nce of): G / / / C CPS nce of):	31 E	EDIA	14		d. Date of delive	AE
g physician and as the burial-transit	edicai	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	b. Due to (or a Due to (or a Due to (or a Due to (or a Due to (or a d.)	is a consequer Solve of the consequer Solve of the consequer	nce of): G / / / nce of): C C S nce of):	BLE V	EDIA	14			AE
he attending physician and ned for use as the burial-transit	edicai	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	b. Due to (or a b. Due to (or a c. Cin Due to (or a d. Due to (or a d. Due to for a d. Due to	is a consequer is a consequer o	nce of): G / / / nce of): C C S nce of):	BLE V	EDIA	14		d. Date of delive	SA(E
he attending physician and ned for use as the burial-transit	edicai	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \)	b. Due to (or a b. Due to (or a c. Due to (or a d. Due to (or	is a consequer S a consequer S a consequer o o o o o o o o o o o o o o o o o o o	nce of): C CPS nce of): C CPS nce of): y eath 3 Ectopic th 5 Other (s	BLE U	CIIVO	1G PUN	230	d. Date of delive Month	ery Day Year
gned by the attending physician and be detached for use as the burial-transit	by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or a b. Due to (or a c. Due to (or a d. Due to (or	is a consequer S a consequer S a consequer o o o o o o o o o o o o o o o o o o o	nce of): C CPS nce of): C CPS nce of): y eath 3 Ectopic th 5 Other (s	BLE U	CIIVO	19- 21-21-23- Di	230	d. Date of delive Month	ery Day Year ne cause of death
been signed by the attending physician and should be detached for use as the burial-transit	by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or a b. Due to (or a c. Due to (or a d. Due to (or	is a consequer S a consequer S a consequer o o o o o o o o o o o o o o o o o o o	nce of): C CPS nce of): C CPS nce of): y eath 3 Ectopic th 5 Other (s	BLE U	CIIVO	239. Di	23d d tobacco use	d. Date of deliver Month contribute to the No 3 Prob	ery Day Year ne cause of death'
has been signed by the attending physician and le 2 should be detached for use as the burial-transit	by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or a b. Due to (or a c. Due to (or a d. Due to (or	is a consequer S a consequer S a consequer o o o o o o o o o o o o o o o o o o o	nce of): C CPS nce of): C CPS nce of): y eath 3 Ectopic th 5 Other (s	BLE U	CIIVO	23e. Di 10 24a. W	23d tobacco use	d. Date of deliver Month contribute to the No 3 Prob	Pary Day Year Day 4 Dunknoopsy findings availa
ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significent conditions	b. Due to (or a b. Due to (or a c. Due to (or a d. Due to (or	is a consequer S a consequer S a consequer o o o o o o o o o o o o o o o o o o o	nce of): C CPS nce of): C CPS nce of): y eath 3 Ectopic th 5 Other (s	BLE U	CIIVO	23e. Di 10 24a. W	23d d tobacco use	d. Date of deliver Month contribute to the contribute and problem in the contribute to the contribute	ery Day Year ne cause of death hably 4 Dinkno
erificate has been signed by the attending physician and sclor, page 2 should be detached for use as the burial-transit	Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significent conditions:	Due to (or a b. Due to (or a c. Due to (or a d	is a consequer S a consequer S a consequer S a consequer S a consequer D	nce of): G / / / / / / / / / / / / / / / / / /	pregnancy specify)	CTIVE	23e. Dii 10 24a. William au pe 10 Yes	23d tobacco use Yes 2 1 as an lopsy formed? 2 1 No	d. Date of deliver Month contribute to the No 3 Proberties Properties and prior to condeath? 1 Yes	Pay Year Day Year De cause of death pably 4 Danknown psy findings availampletion of cause 2 \(\subseteq \text{No} \)
his certificate has been signed by the attending physician and it director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or a b. Due to (or a c. Cin Due to (or a d. Due to (or	is a consequer is a consequer or of pregnance prediction of deat but not resulting	nce of): G / / / / / / / / / / / / / / / / / /	pregnancy specify) cause give	CTIVE	23e. Dii 10 24a. Wi pe 11 Yes Peath Check on 11 Home 5 Re	23d tobacco use Yes 2 1 as an lopsy formed? 2 1 No one sidence 6	d. Date of deliver Month contribute to the No 3 Proberty Prior to condeath? 1 Pes	ery Day Year ne cause of death pably 4 Dinkn psy findings avail mpletion of cause 2 No
this certificate has been signed by the attending physician and rat director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or a b. Due to (or a c. Cin Due to (or a d. Due to (or	is a consequer is a consequer is a consequer of pregnancy 2 Fetal deat time of deat but not resulting but not resulting tient 2 ER	nce of): G G G G G G G G G G	pregnancy specify) cause give	CTIVE 26. Place of I	23e. Dii 10 24a. Wi pe 11 Yes Peath Check on 11 Home 5 Re	23d tobacco use Yes 2 1 as an lopsy formed? 2 1 No	d. Date of deliver Month contribute to the No 3 Proberty Prior to condeath? 1 Pes	Pay Year Day Year De cause of death pably 4 Danknown psy findings availampletion of cause 2 \(\subseteq \text{No} \)
this certificate has been signed by the attending physician and rat director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or a b. Due to (or a c. Due to (or a d	is a consequer is a consequer is a consequer of pregnancy 2 Fetal de at time of deat but not resulting but not resulting tient 2 ER jury ay Year) 28	nce of): Organic Street Stree	pregnancy pregna	CTIVE	23e. Dia 23e. Dia 10 24a. Wa au 11 24a. Wa 11 24a. Wa 11 24a. Wa 24a. Wa 24a. Wa 25a. Dia 26a. Dia 27a. Dia 28d. Describ	23d tobacco use Yes 2 1 as an lopsy formed? 2 1 1 No one sidence 6 e how injury of	d. Date of deliver Month contribute to the cont	Pary Day Year The cause of death' Pably 4 Dunkno
this certificate has been signed by the attending physician and rat director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or a b. Due to (or a c. Due to (or a d	is a consequer is a consequer is a consequer of pregnancy 2 Fetal de at time of deat but not resulting but not resulting tient 2 ER jury ay Year) 28	nce of): G G G G G G G G G G	pregnancy pregna	CTIVE 26. Place of I	23e. Dii 24a. Wi 24a. Wi 24a. Wi 25	23d tobacco use Yes 2 1 as an lopsy formed? 2 1 1 No one sidence 6 e how injury of	d. Date of deliver Month contribute to the cont	ery Day Year ne cause of death; pably 4 Dinkno
this certificate has been signed by the attending physician and rat director, page 2 should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or a b. Due to (or a c. Due to (or a d	is a consequer is a consequer is a consequer or of pregnance 2 Fetal de at time of deat but not resulting tient 2 ER jury ay Year) 28	nce of): Order of): Order of): Order of): Order of): Order of): Over of injury More, farm, street, factoric discussions of injury More, farm, street, farm, street, farm, street, farm, street, farm, street, farm, street	pregnancy specify)	CTIVE 26. Place of I 4 Nursing at ? (es. 2 No	23e. Dia 24a. Wi au pe 1	d tobacco use Yes 2 1 as an lopsy formed? 2 No one sidence 6 e how injury of the country of th	d. Date of deliver Month contribute to the No 3 Proberties autoprior to condeath? 1 Ves Other (Specify accurred	ery Day Year ne cause of death bably 4 Dinkno psy findings availa mpletion of cause 2 No No No No No No No No No No
this certificate has been signed by the attending physician and rat director, page 2 should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or a b. Due to (or a c. Cin Due to (or a d. Due to (or	is a consequer is a consequer is a consequer is a consequer is a consequer 2 Fetal de at time of deat but not resultin but not resultin iuny lay Year) 28 injury - At home atc. (Specify) ist of my knowle of examination	nce of): Organic Street of Street o	pregnancy pregna	CTIVE CTIVE CTIVE 26. Place of E 4 Nursing at ? (es 2 No	23e. Die 24a. Wie 24a. Wie 1 Yes Peath Check on 28d. Describ 28f. Location City or 7	23d I tobacco use Yes 2 1 Is an lopsy formed? 21D No one sidence 6 e how injury of (Street and Nown, State)	d. Date of deliver Month contribute to the contribute to the contribute to the contribute to the contribute to the contribute to the contribute to contribute to contribute to the contribute contribute to the contribute contribute to the contribute contribute to the contribute contribute to the contribute contribute to the contribute	pay Year ne cause of death of the pably 4 Denknot opsy findings availampletion of cause 2 No No No No No No No No No No
this certificate has been signed by the attending physician and rat director, page 2 should be detached for use as the burial-transit	edical Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or a b. Due to (or a c. Due to (or a d	is a consequer is a consequer is a consequer is a consequer is a consequer 2 Fetal de at time of deat but not resultin but not resultin iuny lay Year) 28 injury - At home atc. (Specify) ist of my knowle of examination	nce of): Organic Street (Street): Organic	pregnancy specify)	CJIVE 26. Place of E 4 Nursing at ? (es 2 No	23e. Die 24a. Wie 24a. Wie 1 Yes Peath Check on 28d. Describ 28f. Location City or 7	as an lopsy of orne sidence 6 (Street and Nown, State) e cause(s) an a, date and pl.	d. Date of deliver Month contribute to the cont	Pary Day Year The cause of death of the cause of death of the cause of death of the cause of the
his certificate has been signed by the attending physician and it director, page 2 should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or a b. Due to (or a c. Cin Due to (or a d. Due to (or	is a consequer is a consequer is a consequer is a consequer is a consequer 2 Fetal de at time of deat but not resultin but not resultin iuny lay Year) 28 injury - At home atc. (Specify) ist of my knowle of examination	nce of): Organic Street (Street): Organic	pregnancy specify)	26. Place of I	23e. Die 24a. Wie 24a. Wie 1 Yes Peath Check on 28d. Describ 28f. Location City or 7	as an lopsy of orne sidence 6 (Street and Nown, State) e cause(s) an a, date and pl.	d. Date of deliver Month contribute to the contribute to the contribute to the contribute to the contribute to the contribute to the contribute to contribute to contribute to the contribute contribute to the contribute contribute to the contribute contribute to the contribute contribute to the contribute contribute to the contribute	Pary Day Year The cause of death? Pably 4 Denkno psy findings availa mpletion of cause of 2 No No No Route Number, Itated.
this certificate has been signed by the attending physician and rat director, page 2 should be detached for use as the burial-transit	edical Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or a b. Due to (or a c. Cin Due to (or a d. Due to (or	is a consequer is a consequer is a consequer is a consequer is a consequer 2 Fetal de at time of deat but not resultin but not resultin iuny lay Year) 28 injury - At home atc. (Specify) ist of my knowle of examination	nce of): Organic Street (Street): Organic	pregnancy specify)	CJIVE 26. Place of E 4 Nursing at ? (es 2 No	23e. Die 24a. Wie 24a. Wie 1 Yes Peath Check on 28d. Describ 28f. Location City or 7	as an lopsy of orne sidence 6 (Street and Nown, State) e cause(s) an a, date and pl.	d. Date of deliver Month contribute to the cont	pary Day Year The cause of death? The cause of death? The cause of death? The cause of death? The cause of death? The cause of death? The cause of death? The cause of death? The cause of death? The cause of death? The cause of death? The cause of death? The cause of death? The cause of death?
this certificate has been signed by the attending physician and rat director, page 2 should be detached for use as the burial-transit	edical Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or a b. Due to (or a c. Due to (or a d	is a consequer is a consequer is a consequer of pregnancy 2 Fetal de at time of deat but not resulting but not resulting tient 2 ER iury lay Year) at of my knowle of examination stated.	nce of): Order of): Order of): Order of): Order of): Order of): Over of	pregnancy specify)	CTIVE 26. Place of E 4 Nursing at ?? (es 2 No e, date and plainion, death or number	23e. Did 24a. With the search Check on City or 7 28f. Location City or 7 ce, and due to the curred at the time	23d In tobacco use Yes 2 Interpret and formed? 2 In No one sidence 6 enow injury of own. State) e cause(s) and and plue 29d. Date s	d. Date of deliver Month contribute to the cont	Pary Day Year The cause of death' Pably 4 Dunknot Pably 4 Dunk
this certificate has been signed by the attending physician and rat director, page 2 should be detached for use as the burial-transit	edical Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or a b. Due to (or a c. Due to (or a d	is a consequer is a consequer is a consequer of pregnancy 2 Fetal de at time of deat but not resulting but not resulting tient 2 ER iury lay Year) at of my knowle of examination stated.	nce of): Garage Alexandrian A	pregnancy specify)	CTIVE 26. Place of E 4 Nursing at ?? (es 2 No e, date and plainion, death or number	23e. Die 24a. Wie 24a. Wie 1 Yes Peath Check on 28d. Describ 28f. Location City or 7	23d In tobacco use Yes 2 Interpret and formed? 2 In No one sidence 6 enow injury of own. State) e cause(s) and and plue 29d. Date s	d. Date of deliver Month contribute to the cont	Pary Day Year The cause of death' Pably 4 Dunknot Pably 4 Dunk

	1	For State Registrar	State of Maryland /	Department of Health and I Certificate of Death	Mental Hygler Reg. I		
Physiciar	1	1. Decedent's Name (First, Middle, Last) FHA LOUIS		n		Day Year	3. Time of Death
/Medica Examined	r	4a. Facility Name (If not institution, give GICHNIST NUTS 5. Social Security Number 6. Sept.	street and number) 5/1/2 Con Fer 7. Age (In yrs. last b	4b. City, Town, or Location of Deat	8. Date of Birth	4c. County of Death Al American 9. Birthy County	place (State or Foreign
Director ≥	T	2/2 33 30(5) Usual Residence of Decedent 10a. State 10b. County	700	wn or Location	FEB. 10,1		CY/AZO 10d. Inside City Limits
vith the Maryl	ector	Narylans Namber		Bs Hugee	100	Citizen of What Cou	1 No 2 No
s 23a or 2		6006 Presco		21212		USA 14. Race - Ameri	
o. in	by Funeral	11. Marital Status 1 Never Married 2 Married Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ ₩6 If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S II Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 225√10 Specify:	pecity Yes or No- to Rican, etc.)	Black, White,	etc.
c 3	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	a. Decedent's Usual Occupation (Give kind of work done during most of wo. life. DO NOT use retired) ### USE CEEPING	rking	. Kind of Business/In	
tal H d off	Re	17. Father's Name (First, Middle, Last)	2 years	18. Mother's Na.	me (First, Middle, Maid		Ami U
2 S S S S S S S S S S S S S S S S S S S	<u> </u>	19a. Informant's Name/Relationship (Ty	rpe, Print) 18	b. Mailing Address (Street and Number or Ri			Code 1216
e ° = 5	-	20a. Method of Disposition ♣ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	come	of Disposition (Name of ery, crematory or other place) Solitory Concher	19/04 Pm	Location - City or To	own, State
permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licens	es a la company de la company	22. Name and Address of Facility 5 90 Res 5 250 M Both Name Mad 201	a dono	- Homs	THURCH
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Schemic Due to (or as a consequence)	contenter the mode of dying, such as cardial conditions yethy e of):	c or respiratory arrest,		Approximate Interval Between Onset and Death
ficate be executed physician and sthe burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence. Due to (or as a consequenced.				
death certing e attending of for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death	th 3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive	ery Day Year
es if	ò	Part II. Other significant conditions co	ntributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacc 1 ☐ Yes	co use contribute to t	he cause of death?
The law requires that the rate has been signed by the page 2 should be detache	Completed				24a. Was an autopsy performed 1 Yes 2	prior to co death?	opsy findings available mpletion of cause of
ding Physician: The h. h. After this certificate h. funeral director, page	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death		Outpatient 3 DOA Other: 4 Nursing H	ath (Check only one) Home 5 The Residence 28d. Describe how in		Mospics
or Attending Physician: ifter death. Director: After this certifics in by the funeral director.	Certification;	1 Shatural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	(Month, Day Year) 28e. Place of Injury - At home, building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No	28f. Location (Street City or Town, St		al Route Number,
le sie b	Medical Ce	(Check only 2 Medical Exam	iner: On the basis of examination.	ge, death occurred at the time, date and place and/or investigation, in my opinion, death occurred.			
To the within 2 To the complete		29b. Signature and title of certifier	and manner stated.	29c. License number 58303		Date signed (Month, huary 4	
7		30. Name and address of person who co Acrom J. Charle	ompleted cause of death (Item 23a	D 58303 V. Charles St Bull	rmore mo	21204	
State Registra	9	31. Date filed (Month, Day, Year) JAN 1 3 2004	32. Registrar's Signature	me			

md 54:1 @)

-03-04

0

ETTA THOMPSON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** NONA L. TUREMAN JANUARY 10 2004 12:02 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 8245 WOODS ROAD MILLERSVILLE ANNE ARUNDEL CO. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex **Funeral** 1 ☐ M 2 💢 F 63 225-48-1768 Jan. 21 1940 Director Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location r Items 23a or 28a-f show therr ust be notified at 1 ☐ Yes 2 ☐ No Director Md. Anne Arundel Co. Millersville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8245 Woods Road 21108 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married ö 1 ☐ Yes 2 X No Specify: Specify: white 7 is marked other than *naturel", o traumatic event, the Madical Extr þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be fi Department of Health and Mental In Important: if item 27 is marked oil any injury or other traumatic even 20x8. Poseno Cora Sam Dillon 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Husband) 8245 Woods Road, Millersville, Md. 21108 George C. Tureman 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition □ Burial 2 □ Cremation 3 □ Removal from State Maryalnd Veterans Cemt.01/14/04 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, Md. 21. Signature of Funeral Service Licensee Name and Address of Facility McCully-Polyniak Funeral Home P.A. m00922 3204 Mountain koad, Pasadena, Md. 21122 Approximate Interval Between Onset and Death 23a. Part 1. Enter the dishoot bear 1 ealle, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** YE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intilated events resulting in death) Last Qualto (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the buriat-transit attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy page 2 should be detached for Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗍 Unknown 23e. Did tobacce use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an 1 ☐ Yes 2 ☐ No Medical Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Fesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: , completely filled in by the f 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Mem 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. GLENBURNIE HOSPITAL 325 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

ORIGINAL

	Star	te of Maryland / Departmen		ental Hygiene	
	Decedent's Name (First, Middle, Last)	Certifica	te of Death	Reg. No	004 00031
Physician	Ti. Decedent's Name (Pirst, Middle, East)	Walton		Month Day	3. Time of Death
/Medical Examiner	4a Fecility Neme (Il not institution, give street e	nd number)	4b. City, Town, or Loc	ation of Deeth c. Coun	y of Death
- Laminer	Stella Maris at M	ercy Hospital	Baltir	nore	NIA
Funeral	5. Social Security Number 6. Sex	1.0	r 1 Year If Under 24 Hrs. Deys Hours Min.	8. Date of Birth (Month, Day Yeer)	9. Birthplace (State or Foreign
Director	Usuel Residence of Decedent	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		Dec.18,1923	South Carolina
erylend show	10a. State 10b. County	10c. City, Town or Location	Hall		10d. Inside City Limits
the Meryle 1288-1 sho notified at	Maryland NIA	Baltim	ore		1 Yes 2 No
Ofre Direct	10e. Street end Number	V HAI	Code	10g. Citizen of	What Country?
1215-0020 within 72 hours effer death with the Menyland ene. Then "natural", or items 23e or 28e-f show the Medical Examinar must be notified at ampleted by Funeral Director	11. Marital Status 12. Was	Decedent Ever in U.S. 13. Was Dece	dent of Hispanic Origin? (Spe	city Yes or No. 14. Ra	ce - American Indian,
S o efference of the contract	Arm	Yes 21X No	dent of Hispanic Origin? (Specify Cuban, Mexican, Puerto F		ack, White, etc.
DO02 DO02 June 1	3 ☐ Widowed 4 ☐ Divorced Yea	r or Dates:		Speci	Black
D M 1 21215-0 led within 72 ho lygien nature it, in Medical Completed	15. Decedent's Education (Specify only highest grede comple	ated) 16a. Decedent's Usu (Give kind of w	al Occupation ork done during most of workingse retired)	g 16b. Kind of E	Business/Industry
212 212 3 withing a withing a second	Elementery/Secondary (0-12) Colle	Weapons	M. f. +	rer U.S	Government
and be filed the dotte of the second.	17. Father's Neme (First, Middle, Last)	1,700,701.3	1 1 1 1 1 1 1 1 1 1	(First, Middle, Maiden Suma	
ylan ylan Ment Ment erked	Levi Blutoro		Effic	Bluton	d
Wayton, Dal. Maryland 21215-0020 and 2 should be filed within 72 hours eft alth end Mentel Hyglene. 27 is marked other than "natural", or rarements event, the Medical Example To Be Completed by F	19a. Informant's Name/Relationship (Type, Prin	(Son) 19b. Mailing Addres	s (Street and Number or Rural		, Stete, Zip Code)
Heelt Heelt Sther	20a. Method of Disposition	20b. Place of Disposition (Na	me of	Date 20c. Location	- City or Town, State
Baltimore, Maryland 2121(permit. Peges 1 and 2 should be filed within 7 Department of Health and Mentel Hygiene. important: If them 27 is marked other than 1 eny injury or other traumetic event, trained page. To Be Comple	1 Burial 2 ☐ Cremetion 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	from State Cemetery, crematory or	other place)	5/20 1	downe, Md.
alti Perim Porter	21. Signatore of Funeral Service Licensee	22. Name a	nd Address of Facility	Laris	sac vorie, ria.
W \$9£28	Joseph L	KUM Joseph	L Kuss Fu	neral Home Baito Md.	71716
	23a. Part1. Enler the disease, or complication shock, or heart fails re. List only one cause	at caus d to death. Do not enter the mo	de of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between Onset and Death
Physician /Medical	Immediate Cause (Final	1			Onset and Death
Examiner	disease or condition resulting in death) e	Due to (or as a consequence of)	inver		:
- P		Due to (or as a consequence of)			
Vision of Vital Records, P.O. Box 68760, Attanding Physician: The lew requires that the death certificate be executed and actor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be deteched for use as the bunel-transit diffication: To Be Completed by Physician/Medical Examiner	Sequentially list conditions,	Due to (or as a consequence of)			
68760, filcete be exemple to be exemple to be exemple to be seen the buriel.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
6876C fficete be g physicia es the bur	resulting in death) Last	Due to (or as a consequence of):			
Box eath cert ettending for use	d				
O. El ne deat the ett the ett ysicia	Pert II. Other significant conditions contributing	to death but not resulting in the underlying	eause given in Part I.	23b. Did tobecco uee co	entribute to the cause of death?
P.(1 ☐ Yes 2 ☐ No	3 Probably 4 Unknown
al Records, P.O. Box is The lew requires that the death certicate has been signed by the ettending page 2 should be deteched for use completed by Physician/M				24a. Was an autopsy	24b. Were eutopsy findings
w req				performed?	availeble prior to completion of cause of death?
I Relevate heres sege 2				1 □ Yes 2 No	1 ☐ Yes 2 ☐ No
of Vital Re Invaicien: The le la list certificate hese I director, page 2	25. Was case referred to medicel examiner?		26. Place of Death	(Check only one)	
Of \Physic this coldine eldire	1 ☐ Yes 2 ☐ No Hospital:	1 Inpatient 2 ER/Outpatient 3 DO		e 5□ Residence 6 ☑Oth	1100101
Offiner After	1 Natural 5 Pending 2 Accident investigation	Date of Injury 28b. Time of 28b. Time of 1njury M	28c. Injury et	ld. Describe how injury occur	red
Division of Vital Records, P.O. or Attanding Physician: The lew requires that the desirence: After this certificate has been signed by the jin by the funeral director, page 2 should be deteched ertification: To Be Completed by Physician or a second property of the completed of the physician of the completed of the physician of the completed of	3 ☐ Suicide 6 ☐ Could not be determined 28e. I	Plece of Injury - At home, farm, street, factor		f. Location (Street and Numi	per or Rural Route Number,
Div tal or si Dire led in I	4 Homicide	ouilding, etc. (Specify)		City or Town, State)	
Division c he Hospital or Attanding Pl n 24 hours effer death. The Funersi Director: Affer th pletely tilled in by the funers edical Certification:	(Check only 2 Medical Examiner: On t	o the best of my knowledge, death occurred he basis of examination and/or investigation	at the time, date and place, an , in my opinion, deeth occurred	d due to the ceuse(s) and mand the time, date and place,	anner as stated. end due to the cause(s)
Division of To the Hospital or Attanding Phywithin 24 hours efter death. To the Funeral Director: After this completely filled in by the funeral dedical Certification: To Medical Certification: To	one) and 29b. Signature end title of certifier	manner steted.	c. License number		d (Month, Dey, Year)
F3F8	- Sulled	7	LIN 8511	1 / 4	2004
4	30. Name and address of person who completed	cause of deeth (Item 23a) (Type, Print)	2.1000-1	1	1 200 -
	BaviD, Riseberg	301 ST. Paul P	Baltimore	mD. 515	50
State∜ Registrar	31. Dete filed (Month, Day, Year)	32. Registrar's Signature	v .		

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

4-00276 AP		For State	State of M	aryland / De		t of H	lealth :	and M		lygiene	jible.	Asso
Physicia /Medic		1. Decedent's Name (First, Middle Kenyon	e, Last)			ital			2. Date of Month JANUA	Day	Year	3. Time of Death 3:20 a M
Examin		4a. Facility Name (If not institution UNIVERSITY HOS) 5. Social Security Number	PITAL	ge (In yrs. last birtho	BALT	LMOR	r Location E CIT	'Y	8 Date of		ty of Death	place (State or Foreign
Funeral Director		218-92-7838 Usual Residence of Decedent	1 X M 2□ F	24 Yr	Months		Hours	Min.	06 (Month,	Birth Day, Year) 21 79	Cou	mtry) MD
the Maryland 28s-f show	Director	10a. State 10b. County MD N I 10e. Street and Number		Baltin		Code				10g. Citizen o		10d. Inside City Limits 1√ Yes 2 □ No
with Mith	i Dir	5405 Nelson A	lve		101. 210		1215			-	. A .	
s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Marked	by Funerai	11. Marital Status 1 📉 Never Married 2 🗆 Mar 3 🗆 Widowed 4 🗆 Divorced	12. Was Decedent Armed Forces?		13. Was Deced If Yes, spec		lispanic Or an, Mexical Specify:		ecify Yes or Rican, etc.)	No- 14. R	ace - Americack, White,	
d within 72 ho jiene. r than "natur itte Wed Gall	Completed		t's Education st grade completed) College (1-4or	16a. D	ecedent's Usua Give kind of wo fe. DO NOT us Cutt		ation during mos d)	it of work	ing	16b. Kind of	Business/In	,
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 ie marked other than any injury or othar traumatic event. Ite M. 900ce.	To Be C	17. Father's Name (First, Middle, Norwood White				The state of the s			e (First, Midd	dle, Maiden Suma ry	атө)	
l and 2 sho lealth and rm 27 le m		19a. Informant's Name/Relations Norwood Whit			Turk (art		Cato		le, Md	212	228
permit. Pages: Department of h Important: If ite any injury or of		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (S	Specify)	woodla	wn Cen	ther plac 1ete d Addre	ery 1	/17			•	Co, Md
Fnysician /Medical Examiner		23a. Part 1. Enter the disease, o shock, or heart lailure. List Immediate Cause (Final disease or condition resulting in death)	a. Due to Pr as	d the death. Do not ine.	enter the mod	laba	sh A	ve	Balt respiratory	imore ! varrest,	Md 2	Approximate Interval Between Onset and Death
ficate be executed physician and is the burial-transit	edicai Examiner	Securities, list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of)								Y
Physician: The law requires that the death certificate to the certificate the certificate has been signed by the attending physical director, page 2 should be detached for use as the to the certificate has the certificate the certificate for use as the certificate for the certificate f	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death	3 ☐ Ectopic pr 5 ☐ Other (sp		,				ate of deliver	ery Day Year
requires that	þ	Part II. Dther significant conditi	out not resulting in the	Iting in the underlying cause given in Part I. 23e. Did							he cause of death?	
an: The law itilicate has b	e Completed	25. Was case referred to medical		24a. Was an autopsy findings availal autopsy performed? 10 Yes 2 No 26. Place of Death (Check only one)							mpletion of cause of	
To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. The law requires that the death cer to the Luneal Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use	tion: To B	examiner? 1 X Yes 2 No 27. Manner of Death 1 Natural 5 Pendia 2 Accident invest	Hospital: 1 Inpati	ury 28b. Tin		8c. Injur Wor	er: 4□Nı	ursing Ho	me 5□Re	esidence 6 0		(y)
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of In	jury - At home, larm tc. (Specify)	, street, factory				28f. Location City or	(Street and Nun Fown, State)	ber or Rura	A Route Number,
the Hospi thin 24 hou the Funer impletely fill	Medical		ng Physician: To the best Examiner: On the basis of and manner st	of examination and/	or investigation	in my o					, and due to	o the cause(s)
6348		30. Name and eddress of person	ofeno	death (Item 23a) (To		oa				JANUAR		2004

State Registrar JAN 1 3 2004

Witte

DHMH 17 Rev 1/2001

39. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Catherine White January 3, 2004 $6:05pm^{M}$ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 3118 Laurel Avenue Cheverly Prince Georges If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Yeer) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 20 F 005-42-8281 86 Director January 2, 1918 ME Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Mudical Examiner must be notified at MD Prince Georges Cheverly 1 Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3118 Laurel Avenue 20785 USA Items 23a Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 📆 No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 6 1 ☐ Yes 2 ☑ No Specity: þ 3 Widowed 4 □ Divorced natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wil Department of Health and Mental Hygiens Importent: if Item 27 is marked other that any injury or other traumatic event, IDS ODGS. Homeneker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Joseph Beulah Cecilia Casey Unk. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Christine E. Boyd / Daughter 3118 Laurel Avenue, Cheverly Maryland 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 ARemoval from State St. Benedicts Cemetery January 10, 2004 Benedicta, ME * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee Victor P. Doda 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 East Fort Avenue, Baltimore MD 21230 Approximate Interval Between Onset and Death as that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) METASTATIC Pnysician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dies to (or as a consequence of) Examiner the attending physicien and hed for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death After Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certified D-33224 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 50w Edmonton Dr #303, Rockville MD 20852 TREHAN MD State Registrar

1. Decedent's Name (First, Middle, Last) Dorothy Hele 4a. Fecility Name (If not institution, give seems)					2. Date of De	Reg. No.		
	T T				_Month	aath Day	Yeer	3. Time of Death
4a. Fecility Name (If not institution, give s	n Wagor	ner			JANUA		2004	12:20 PM
	street and number)			or Location of Death		4c. County	of Deeth	
	SALTH CAR			TIMORE If Under 24 Hrs.	T	N/A		
5. Social Security Number 6. Sex 1	7. Age (In) IM 2≧F 85	vrs. last birthday Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da Aug • 1	5, 1918	9. Birthp Coun Mar	lece (State or Foreig try) y Land
Usual Residence of Decedent						-		/
10a. State 10b. County		City, Town or L					11	Od. Inside City Limits
Maryland Baltimor	e l	Baltimor						1 ☐ Yes 2 ☐ No
10e. Street and Number 210 Mine Bank Lan	e		10f. Zip Code 212:	27		10g. Citizen of \	Vhat Coun	try?
11. Marital Status		n U.S. 13.	Was Decedent of H	lispanic Origin? (Sp	ecify Yes or No			
1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 No				Rican, etc.)		Wh:	etc. ite
3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		10 165 20 NO	Specity.		Specin	′′ 	
		16a. Dece	edent's Usual Occup kind of work done	pation during most of work	ing	16b. Kind of B	siness/Inc	dustry
Elementary/Secondary (0-12)	College (1-4or 5+)		_	u)		Own	Home	
17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle	, Maiden Suman	10)	•
Carl Mu	hlbauer			Teresa	Lena	Wagr	er	
19a. Informant's Name/Relationship (Ty	oe, Print)	19b. Mail	ing Address (Street	and Number or Rur	al Route Numb	er, City or Town,	State, Zip	Code)
					The second of			
		cemetery, cre	matory or other pla	ce) i			•	
* 4 □ Donation 5 □ Other (Specify)	(B a	Loudon	Park	ry 1/10				
21. Signature of Funeral Service License	90	2						
23a. Part Enter the disease, or compli	cations that caused the d	leath. Do not en					2122	Approximate
Shock, or heart failure. List only or Immediate Cause (Final	e cause on each line.				. ,			Onset and Death
disease or condition resulting in death)			AL PNE	UMONIA				3 DAYS
								2 DAYS.
if any, leading to immediate cause. Enter Underlying								
that initiated events								
	Due to (or as a con-	sequence on:						
IF FEMALE:						23d. Dat	e of delive	rv
in the past 12 months?	4☐Pregnant at time			/				Day Year
9 Unknown	9LI Unknown							
	-	resulting in the t	inderlying cause giv	en in Part I.				
DEMEN (7)	*				10	Yes 2LVNo	3∐ Proba	abiy 4 Unknown
					autor	psy r	rior to con	psy findings available appletion of cause of
					1 ☐ Yes	2 No 1	Yes	2□ No
examiner?	ospital:	- CI FD/0	Oth					
27. Manner of Death	28a. Date of Injury	28b. Time o	nt 3∐ DOA of 28c. Injur	4 ☐ Nursing Ho)
1 Natural 5 Pending	(Month, Day Year	r) Injury						
3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - A	At home, farm, st	reet, factory, office				er or Rural	Route Number,
4 _ Homeldo	building, etc. (Sp.					wii, State)		
29a. Certifier 1 Certifying Physical Check only 2 Medical Examin	ician: To the best of my	knowledge, dear	th occurred at the tir	ne, date and place, pinion, death occur	and due to the red at the time.	cause(s) and ma	nner as sta	ated. the cause(s)
one)	and manner stated.							
	VA2AA: AA	Mhud	M. D			_		
			Print)	1 1010.		JANUAL	KY O	1, 2004.
	· •			IE BALT	IMORE	2:229		
31. Date filed (Month, Day, Year)		9	10 B	K p	,	,		
	3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Carl Mul 19a. Informant's Name/Relationship (Ty) Carroll M. Wagone: 20a. Method of Disposition 1 Burial 2 Woremation 3 R 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 23a. Part Ther' the disease, or complistions of the part failure. List only on Immediate Cause (Final disease or condition resulting in death) 23a. Part Ther' the disease, or complistions or conditions or part failure. List only on Immediate Cause (Final disease or condition resulting in death) Euquentially list sunditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions con DEMENTIAL 25. Was case referred to medical examiner? 1 Yes 2 No 9 Unknown Part II. Other significant conditions con DEMENTIAL 25. Was case referred to medical examiner? 1 Yes 2 No 9 Unknown 27. Manner of Death 1 Matural 5 Pending investigation 6 Could not be determined 29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examinary one) 29b. Signature and title of certifier MURTA 2A M NA NA M NA NA NA NA	Sequentially list outsides Sequentially l	15 Decedent's Education 16a. Decedent 16a. Decedent's Education 16a. Decedent's Education 16a. Decedent's Education 16a. Decedent's Education 16a. Decedent 16a. Decedent's Education	Society only highest grade completed	Yes. Gypen 1 Yes. Car or Dates: 1 Yes. 2 Yes or or Dates: 1 Yes. 2 Yes or or Dates: 1 Yes. 2 Yes or or Dates: 1 Yes. 2	Security Security	Specific Specific	Specify Spec

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registre Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death WEINBE Month Dav Year **Physician** TUYA 5:35 AM JAN 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Randallstown Baltimore Chapel Hill Nursing Center 7. Age (In yrs. last birthday)

On Yrs. | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day), Year)

On Yrs. | Months | Days | Hours | Min. | Dec. | 11, 1913 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🔼 F Virginia Director 217-03-1805 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Show rthan "netural", or items 23a or 28e-f shov the Medical Examiner must be notified at Arbutus Maryland Baltimore 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 5620 Branfield Road 21227 USA death v Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if item 27 is marked other than "netural", or iten any injury or other traumatic event, the Medical Examinations. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates: Specify ģ 3 € Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hubert Pettie Nettie Gertrude Woodard 19a. Informant's Nama/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5620 Branfield Road, Arbutus, MD 21227 Nancy G. Maith (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ty□ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/9/04 Loudon Park Cemetery Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Panil. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MUNITE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner signed by the attending physician and d be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Munknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed? certificate 1 ☐ Yes 1 Yes 2 No 2 No To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this ctor: After this y the funeral c 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 1 ☑ Natural 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending within 24 hours after death. To the Funeral Director: A investigation М 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) determined filled in by 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier, 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H.Q KU1500 32. Registrar's 31. Date filed (Month, Day, Year) State Registrar

			1 - For State Registrar		State of	Marylar	_	artmen rtificate				Mental Hyg	giene Reg. No	UL	0659	5
	Physici	an	1. Decedent's Name (First, Midd					-				2. Date of De	ath Day	Year	3. Time of Dea	ath
	/Media	cal	FULLE		NKLER			4h Cit.	T	Location	-f Danth	JANUAR	24 08	2004	0152	М
	Examir	ier	4a. Facility Name (If not institution University of Ma				ter		time		of Death		4c. Coun	ty of Death		
	Funeral		5. Social Security Number	6. Sex			last birthday)	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Birt October	h v Year)	9. Birthp	lace (State or Fo	reign
	Director		217-66-4570	10	M 21XF	47	Yrs.	Wionara	Days	riours	Will I.	October	"8 , 1956	Mary	Zand	
	land ow		Usual Residence of Decedent 10a. State 10b. Count	,		10c. C	ity, Town or Lo	cation		•				1	0d. Inside City Li	mits
	a-feh	ţċ	Maryland Anne	Arun	de1	G1	en Bur	nie							1 ☐ Yes 2 ₹]No
	or 28	Olrec	10e. Street and Number					10f. Zip	Code				10g. Citizen of		•	
	s 23e	ral	1212 Guildford				10		1060		: 0.10		United			
396	d within 72 hours after death with the Maryland jene. rrthan "natural", or Itams 23a or 28a-1 ehow The Medical Exercites must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Ma 3 ☐ Widowed 4 ☐ Divorce	ried	Armed For 1 Yes 1 Yes, Give Year or Da	2 [<u>%</u> No		was Deced f Yes, spec 1 ☐ Yes 2	ify Cubar	spanic Ori n, Mexicar Specify:	i, Puerto	ecify Yes or No- Rican, etc.)		ice - Americ ack, White, i		
2-0	72 hor	eted	15. Deceder (Specify only higher	nt's Educ	ation		16a. Dece	dent's Usua	l Occupa	tion	t of work	ring	16b. Kind of I	Business/Inc	lustry	
2121	75 - 7	Completed by	Elementary/Secondary (0-12)	Jacob	College (1-	4or 5+)		kind of wor DO NOT us WOTK		aring mos	t or work		Fact	ory		
land	ould be filed Mental Hygid arkad other atic evant, I	To Be (17. Father's Name (First, Middle Gordon Jones	Last)						18. Mothe Rut	_	e (First, Middle, Beeson	Maiden Suma	me)		
, Mar	12 sho h and 7 Is m traum		19a. Informant's Name/Relation Joseph E. Wink									a <i>l Route Numbe</i> Glen Bur			code) id 21060	1
Baltimore, Maryland 21215-0036	(n) - := 0		20a. Method of Disposition 1 △ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3)		moval from S	State	Place of Dispo cemetery, crer udon P	natory or ot	her place			Date 2-2004	20c. Location Baltim			
Balti	parmit. Page Department of Important; If any injury or once.		21. Signature a Funeral Serfvice	License	HOT A	DW)	22 T.	. Name and	Address	of Facilit	y lera	l Home	more.	Marv1a	and 2122	— 29
	cate be exacuted XX Medical physician and the burial-transit the burial-transit	dical Examiner	23a. Part 1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	r defindlich tonly one a. b. c. d.	Due to (c	used the dearch line. A TO TO TO TO TO TO TO TO TO TO TO TO TO	quence of):	er the mode		, such as	cardiac	or respiratory ari	rest,		Approximate Interval Between Onset and Death	
.O. Box 68	the death certiff y the attending chad for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23	1 Live bir	ome of pregn th 2 ☐ Feta int at time of c wn	uldeath 3□	Ectopic pre Other (spe						ate of deliver	y Day Year	
α.	es that ignad b be deta	þ	Part II. Other significant conditi	ons conti	ributing to dea	ath but not res	sulting in the ur	nderlying ca	iuse givei	n in Part I.		23e. Did to	_		e cause of death?	
<u> </u>	Tha ate h	Completed								·		24a. Was a autops perform	an 24b. sy ned? 2 No	death?	sy findings available to the state of the st	able of
Vital	nding Physician: 1 th. : After this certifica funeral director, p	Be	25. Was case referred to medical examiner?	-							of Death	(Check only or				
of	Physi this c	-T	1 Yes 2 No	no			ER/Outpatien 28b. Time of		A Other	40140		me 5 Residence 128d. Describe he				
on	Attending r death. actor: After by the fune	tlon	1 ✓ Natural 5 ☐ Pendi	ng igation	28a. Date of (Month	, Day Year)	Injury	м	Work?	? es 2 ∐if		Edd. Describe III	ow injury occur	100		
Division of	or Direction	Certification;	3 Suicide 6 Could 4 Homicide deter		28e. Place o	of Injury - At h g, etc. (Specia	ome, farm, stre y)	eet, factory,	office		Ī	28f. Location (S City or Town		ber or Rural	Route Number,	
	Hospita 4 hours Funeral 1ely filla	edical C	29a. Certifier (Check only one) 1 Certifyi 2 Medical	ng Physi Examine	cian: To the ter: On the bas	sis of examina	owledge, death	occurred a restigation,	it the time in my opi	o, date and nion, deat	d place, th occurr	and due to the c ed at the time, d	ause(s) and m late and place,	anner as sta and due to	ted. the cause(s)	
	To the within 2 To tha comple	Me	29b. Signature and title of certifie		0/			29c.	License	number		2	9d. Date signe	ed (Month, E	lay, Year)	
)			> Affine	148	Whe			_ {	717	742			1/8/	04		
	5	(a)	30. Name and address of person ALAN KUSA	KAP	DE 2	37,1	W. LAS	Print) VVALE	ST	, B	ALT	IMORE,	Mo-	2121	 	
à	Sta Registr		31. Date filed (Month, Day, Year		32. Re	gistrar Signa	iture &	Low	sale)							

			1 = For State Registrar	State of Marylar		artment of F ctificate of			jiene leg. No.		00568
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea	th		3. Time of Death
	Physici /Medio		MACIE	5.		WYL	1 1 E	JANUARY	Day [2004	12:12 PM
)	Examir		4a. Facility Name (If not institution, give	street and number) AYVIEW MEDILI	AL CENTE	4b. City, Town, o	LT /MILLE		4c. C	County of Death	
	Funeral Director		5. Social Security Number 6. Security 220–20–6131	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 01-31-1	Year) 910	Cou	place (State or Foreign ntry) C
	pu .		Usual Residence of Decedent 10a. State 10b. County	10c Ci	ty, Town or Lo	cation					10d. Inside City Limits
	•ho	ō	MD BALTIMO								1X Yes 2 No
	28a-	Director	10e. Street and Number	KE 10	KNEKS	STATION 10f. Zip Code		1	IOa. Citize	en of What Cou	ntry?
	3a or	<u></u>	545 MAIN STREET			21222			U	SA	,
	deat deat	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	l.S. 13. \	Vas Decedent of H	lispanic Origin? (Si an, Mexican, Puerti	pecify Yes or No-	14	4. Race - Ameri Black, White,	
21215-0036	be filed within 72 hours after death with the Maryland stat Hygiene. Ided other then "natural", or Hems 23s or 28s-1 show event, the Modical Examine than the multised at	þ	1 ☐ Never Married 2 ☐ Married 3XXWidowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		Yes 2 XNo	Specify:	Tribari, oto.,	s		ACK
20	72 hc	Completed	15. Decedent's Edu (Specify only highest grad		(Give	ent's Usual Occup	during most of wor	king	16b. Kind	d of Business/In	ndustry
12	hen vithin	ш	Elementary/Secondary (0-12)	College (1-4or 5+)	HOUSE	OO NOT use retired	d) -			HOMB	
Б	Hygie Hygie thar t	CO	17. Father's Name (First, Middle, Last)		HOUSE	WILE	18. Mother's Nam	ne (First, Middle, I		HOME	
Maryland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Itam 27 Is marked other then any niury or other traumatic event, Its MODGs.	To Be	PAUL JACKSON				ISABE	LLA ER	VIN		
Mar	d 2 sh th and 7 Is m traum		19a. Informant's Name/Relationship (Ty	•			and Number or Ru				o Code)
	1 and Healt am 2		LILA MAE ESPIE/DAU 20a. Method of Disposition	20b. F	Place of Dispos	sition (Name of	LAND ROAD			21244 ation - City or To	own. State
nor	ages ont of t: If it y or o		1 XBurial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, cren RBUTUS	natory or other plac		6/2004		TIMORE,	
Baltimore,	artine cortan cortan njur		21. Signature of Funeral Service License			. Name and Addres					
B	Departiment import		(James a	Marton			JA RENS ST.,				S F.H., INC
			23a. Part. Enter the disease, or complishock, or heart failure. List only or	cations that caused the deat						2.1.2.17	Approximate Interval Between
	- Physician	și q	Immediate Cause (Final disease or condition	PNEUMON	ICA						Onset and Death
100 m	/Medical Examiner	Ų	resulting in death)	Due to (or as a conseq							1-000
	Lxammer	L	Sequentially list conditions,	. INFLUEN							14 1495
	bed isrt	nlne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	juence on:						
1	and and al-train	Examiner	that initiated events resulting in death) Last	Due to (or as a conseq	juence of);						
8760,\	icate be executed physician and s the burial-transit	dlcal E		1.							
9		a)									
Š	th cer tendir r use	an/N	230. Was decedent pregnant	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnancy			230	d. Date of delive	
.O. Box	The law requires that the death certifi ale has been signed by the attending page 2 should be detached for use a	Physician/M	in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	4☐Pregnant at time of d		Other (specify)				Month	Day Year
۵.	hat th od by detact	Phy	Part II. Other significant conditions cor	stributing to death but not res	ulting in the ur	derlying cause give	en in Part I	23e Did tob	acco use	contribute to t	he cause of death?
Division of Vital Records,	signe d be	d by	3		oung in the of	activity occusor give	or are a				pably 4 □Unknown
Sor	w requir been si should	Completed						24a. Was a	, ,	24h Were sute	psy findings available
Be	The lay	dmo						autops	y ned?	prior to co death?	mpletion of cause of
ta		O	25. Was case referred to medical				26 Place of Deal	1 ☐ Yes 2 th (Check only on	2 (X) No	1 🗆 Yes	212(No
<u> </u>	Physicien: r this certifica ral director, I	To B	examiner? 1 ☐ Yes 2 🔀 No	lospital: 1 🔀 Inpatient 2 🗆	ER/Outpatient	3□ DOA Oth	or	ome 5 Reside		□Other (Specif	(v)
0 4	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Worl	/ at	28d. Describe ho			
Sio	Attending or death. ector: After by the fune	catle	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No				
Ξ	I or Attendate death Director:	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif		et, factory, office		28f. Location (St. City or Town	reet and f i, State)	Number or Rura	I Route Number,
_			29a. Certifier 1 ☑ Certifying Phys	sician: To the best of my kno	wledne death	occurred at the tim	ne date and place	and due to the co	use/s) a-	nd manner as a	tated
	To the Hospite within 24 hours To the Funeral completely filled	edical	(Check only 2 Medical Examile one)	ner: On the basis of examina and manner stated.	tion and/or inv	estigation, in my of	pinion, death occur	red at the time, da	ate and pl	lace, and due to	the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier			29c. License		25	9d. Date s	signed (Month,	Day, Year)
)	D		Llim	MO. MO		RES	-000	j	ANUA	KY 11,	2004
	")		30. Name and address of person who co			Print)	BATIMOR				
	/		PENNAN BARRY	4940 5A5113		1210012	17 M / MARK	r, MU		- (am am /	
\$57 A.	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture /	/					

Гуr	one Wi	11:	iams 1- State Registrar Unpend Item #	State of Mar	uland / Dane	artment of H	loolth and N	lental Hygie	ene .	
			1. Decedent's Name (First, Middle, Las.	23a,2/,28a-t,	Per ME, 682	8,3/4/04eg	Jealii	2. Date of Death	No. East of Later	3. Time of Death
	Physicia	an		onald	Wilson	1		Month	Day Year	M
	/Medic Examin		4a. Facility Name (If not institution, give		, , ,		Location of Death	January	3 2004 4c. County of Death	」925 a [™]
	Examin	er	Johns Hopkins Ho				imore		•	
	Funeral Director		220-36-3100	7. Age ((In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey, Y	ear) 9. Birth Cou	place (State or Foreign intry) Yeanc
7	and * ·	-	Usual Residence of Decedent 10a, State 10b, County	1	Oc. City, Town or Lo	ocation				10d. Inside City Limits
	f sho	ō	md		Baltin	NORE				1 Yes 2 No
į	1.08 1.08 1.00 1.00 1.00 1.00 1.00 1.00	rec	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Cou	intry?
1	23a o	Funeral Director	925 N. BROG	dway		2120	05		USA	
1	ams (ner	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.1	Was Decedent of H		ecify Yes or No-	14. Race - Ameri Black, White	
ထ္က	or its	F	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give		1 ☐ Yes 2 No	Specify:	riioari, Oto.)	Specify: BL	
8	within /z nours atter death with the maryland ene. 10. 11. Itan "netural", or items 23a or 28e-f show the Medical Examinat must be notified at the Medical Examinat must be notified at the Medical Examinat must be notified at the Medical Examinat must be notified at the Medical Examinat must be notified at the Medical Examination of the Medic	d by	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:						
רַלי	"net	Completed	15. Decedent's Ed (Specify only highest grad	de completed)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of work	ing	b. Kind of Business/Ir	
12	than than	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		Hact Se		Rep	Account.	s Keter
0	be filed within 72 hours after death with the Marylan belied with 4 Hygiene. A charthan "netural", or Items 23a or 28e-1 show event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, Ma		
a	marked marked	To B	JAME W W.	locio			Louis	e Pric	re	
Maryland 21215-0036	ges 1 and 2 should it of Health and Mer if item 27 is marke or other traumatic		19a. Informant's Name/Relationship (7					al Route Number, C	City or Town, State, Zi	
	and 2 salth a n 27 l	1	1) errick Wils	011	7		LOCK AN		6. rud. ¿	
Baltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.	-	20a. Methodrof Disposition 1 Burial 2 Cremation 3	Removal from State	20b. Place of Dispo cemetery, crer	osition (Name of matory or other place COMEFER		Date 20	c. Location - City or T	
Ë	Pages ment of ent: If it ury or o		*4 □ Donation 5 □ Other (Specify		Voshell	Cemeter	9 1/10	104	Ballo. W	
3alt	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Fervice Ucen:	500	22	2. Name and Addre	s of Facility	ar Chas	N. DRO	adway
	005 6 d		23a Part 1. Enter the disease, or comp	W.	10	1			700070	7xa. 21213
12	Physician /Medical Examiner		shock, or heart failure. List only of mmediate Cause (Final disease or condition resulting in death)	Narcotic a. Airway	Intoxication consequence of):	n Complicat	ed by Aspi	ration of I	Food into	Approximate Interval Between Onset and Death
	Ited	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	consequence of):					
ć	be executed icien and burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as a c	consequence of):					
760,	te be ysicie ie bur	cai		d						
68	tificat ig phy as th	ba								
.O. Box	the death certificate be executed y the attending physicien and tched for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tin 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
٠ :	that the de ed by the a detached	H.	Part II. Dther significant conditions co	ontributing to death but	not resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ds	uires sign ld be	d by						1 ☐ Yes	2 No 3 Pro	bably 4 Dunknown
Vital Records,	The law requires that ate has been signed b age 2 should be deta	Completed						24a. Was an	24b. Were auto	posy findings available
Re	The lay ate has page 2	mc						autopsy performe 1 Yes 2	d? prior to co	opsy findings available ompletion of cause of
		0	25. Was case referred to medical				26. Place of Deat	1 ☐ Yes 2 h (Check only one)	No 1 ☐ Yes	2. No
>	Physician: this certific ral director,	O B	examiner? 1 ☆Yes 2 ☐ No	Hospital:	2 ER/Outpatier	nt 3 DOA Oth	ar:		e 6 □Other (Speci	fv)
		n: T	27. Manner of Death	28a. Date of Injury (Month, Day Y	(eer) 28b. Time of	f 28c. Injun Worl	/ at k?	28d. Describe how	injury occurred	
<u>.</u>	a ta :: e	atic	1 Natural 5 Pending investigation	12/31/03	11:33	P ^M 1□	Yes 2★No	unknown		
Division	or Attanding after death. Diractor: Afte in by the fune	Certification:	3 ☐ Suicide 6 N Could not be 4 ☐ Homicide determined	_ building, etc.	/ - At home, farm, str (Specify)	reet, factory, office		28f. Location Stree City or Town, S	et and Number or Rur State)	el Route Number,
	oitel ours af			found in re			-			Ltimore,MD 212
	To the Hospitel or Atta within 24 hours after de To the Funaral Diracto completely filled in by the	Medical	(Check only 2 Medicel Exam	vsicion: To the best of eximer: On the basis of example and manner state	xamination and/or in	vestigation, in my o	pinion, death occur	red at the time, date	and place, and due t	o the cause(s)
	돌 돌 돌 등	5	29b. Signature and title of certifier			29c. License	a number	29d	. Date signed (Month,	
	To the To the comp	-	25b. Signature and title obcertings					7.		
)	Some some		> Signature and title dycernia			OCM		Jā	anuary 12	
1	Law and Market)	30. Name and address of person who of Theadore M. Kir		th (Item 23a) (Type,	OCM	E		anuary 12	

atment of Health and Mental Hygiene. ortant: if item 27 is marked other than "naturel", or itema 23a or 28a-1 ahow ortant: if item 27 is marked other than "naturel", or itema 23a or 28a-1 ahow ortant: injury or other traumatic event, trained and itema in the completed by Funeral Director To Be Completed by Funeral Director	4a. Facility Nar VA S. Social Secu Usual Residen 10a. State	The first institution, give ARYLAN A The YLAN A The Number VKN 6. Sec. 15 232 The of Decedent 10b. County The Number The Amount	street and number) Health Ca T. Age (In yrs. 5) 10c. Ci 12. Was Decedent Ever in U Ameriforces? 10 Yes 2 No	PRE last birthday) 7 Yrs. Ty, Town or Local Ball()	4b. City, Town, or Per K. If Under 1 Year Months Days attion MORC 10f. Zip Code	Location of Death Light Folia Under 24 Hrs. Hours Min.	1_	Pay Year 2004 4c. County of Deeth C: C 1 L th y, Year) 9. Birth 19. Year 19. Worth 1	3. Time of Death 7. CO A M place (State or Foreign nity) CAROLIN 4 10d. Inside City Limits 1 12 as 2 \(\) No
/Medical Examiner Funeral Director	4a. Facility Nar VM S. Social Secu Usual Residen 10a. State	The (If not institution, give the YLAN dirty Number with 6. Second 10b. County with 10b. County with Number TREAMOUNTS	street and number) A COLTH CO 7. Age (In yrs. 10c. Ci 12. Was Decedent Ever in U Ameri Forces? 1 10 Yes 2 No	Relast birthday) 7 Yrs. Ny, Town or Local Balli	4b. City, Town, or Per K. If Under 1 Year Months Days attion MORC 10f. Zip Code	24 Poir	8. Date of Bin (Month, Da	4c. County of Deeth C:CIL h, Year) 7 F NOTE	place (State or Foreign intry) CAROLINIA 10d. Inside City Limits
Examiner Funeral Director	5. Social Secu Usual Residen 10a. State	HRYLANd ity Number UKIN 6. Sel. 5333 16 ce of Decedent 10b. County I Number TREAMOUNT tus Married 26 Married	A Pearth Ca 7. Age (In yrs. 5 10c. Ci 12. Was Decedent Ever in U Amed Forces? 11 Was 2 No	PRE last birthday) 7 Yrs. Ty, Town or Local Ball()	Per. K If Under 1 Year Months Days ation MORC 10f. Zip Code	24 Poir	8. Date of Bird	CeCIL h, Year) 9. Birth Cou 146 Noth	10d. Inside City Limits
Director	Usual Resident 10a. State	ity Number Vivia 6. Se. 3.3.2 15 ce of Decedent 10b. County I Number TREAMOUNT tus Married 2 Married	7. Age (In yrs. 7. Age (In yrs. 10c. Ci 12. Was Decedent Ever in U Ameriforces? 10 Yes 2 No	last birthday) Yrs. No. 100 August 100 Augu	If Under 1 Year Months Days ation M B C C 10f. Zip Code	Inder 24 Hrs.	8. Date of Bird (Month, Da	y, Year) 9. Birth	10d. Inside City Limits
Director	Usual Resident 10a. State	ce of Decedent 10b. County I Number TREAMOUNT tus Married 2 Married	10c. Ci	7 Yrs. Nown or Local Balder	Months Days ation MORC 10f. Zip Code		8. Date of Bin (Month, Da	-46 Noth	10d. Inside City Limits
	10a. State	10b. County I Number I RED MOU	10c. Ci	ty, Town or Local	ation MBRC 10f. Zip Code		10-25	-46 Noth	10d. Inside City Limits
lal Hygene. dother than "naturel", or lieme 23e or 28e-1 ahow byent, tra Medical Exardirer must be notified at Be Completed by Funeral Director	10a. State	10b. County I Number Red Mointus Married 2 Married	12. Was Decedent Ever in U Ameri Forces? 1 O'Yes 2 No	Baldy	MORC 10f. Zip Code		•		/
la Hygene. dother than "naturel", or liema 23a or 28a-1 ahou byent, Ira Medical Exacticer must be collified at yeart, Be Medical Exacticer must be collified at Be Completed by Funeral Director		TREDMOUNTERS	12. Was Decedent Ever in U Ameri Forces? 1 O'Yes 2 No	Baldy	MORC 10f. Zip Code				/
la Hygiene. d other than "naturel", or Itema 23a or 28a-f avent, If a Medical Examinar must be notified event, If a Medical Examinar must be notified. Be Completed by Funeral Director	10e. Street and 500 11. Marital Sta 1 Never 3 Widow	Number FRED MOUNT tus Married 215 Married	12. Was Decedent Ever in U Armed Forces? 1 ∑Yes 2 ☐ No		10f. Zip Code				162 163 2 110
la Hygiene. 4 other than "naturel", or itema 23a or 2 svent, it a Medical Examiner must be to svent, Be Completed by Funeral Dire	10e. Street and 500 11. Marital Sta 1 Never 3 Widow	TRED MOU	12. Was Decedent Ever in U Armed Forces? 1 ∑Yes 2 ☐ No						
lal Hygiene. dicher than "naturel", or Itema 23s event, tra Medical Exacticar must event, tra Medical Exacticar must event, tra Medical Exacticar must event, tra Medical Exacticar must event.	11. Marital Sta 1 Never 3 Widow	Rus Married 25 Married	12. Was Decedent Ever in U Armed Forces? 1 ∑Yes 2 ☐ No			4 13		10g. Citizen of What Cou	ntry?
la Hygiene. d other than "naturel", or item event, tra Medical Examinar in Be Completed by Fune	11. Marital Sta 1 Never 3 Widow	Married 21 Married	Armed Forces? 1 ☑ Yes 2 ☐ No			217		USH	
la Hygiene d other than "naturel", or event, tra Medical Exarti Be Completed by F	3 Widow	-		.S. 13. Wa	as Decedent of Hi Yes, specify Cuba	ispanic Origin? (Sp p., Mexican, Puerto	pecify Yes or No Rican, etc.)	- 14. Race - Ameri Black, White	
d other than "natural swent, tra Medical E.	Elementary/	ed 4 Divolced	If Yes, Give Year or Dates:	1 🗆	Yes 2 No	Specify:		Specify: B	ack
other than "naile event, tra Medic Be Complete	Elementary/	15. Decedent's Edu		16a Danadas	ada Harral Oarra			18 16 1 18	
d other than	Elementary/	Specify only highest grad	le completed)	(Give kir.	nt's Usual Occupa nd of work done of NOT use retired	during most of work	king	16b. Kind of Business/Ir	dustry
went, Be Cc		Secondary (0-12)	College (1-4or 5+)		AgenT	_		LASURANC	e
S S	17. Father's Na	ame (First, Middle, Last)			719011	18 Mother's Nam	a (First Middle	Maiden Sumame)	
0 0	,	ter Wimbo	us h					maidon comano,	
s marke sumatic		t's Name/Relationship (Ty		105 145-55-	Address (Character	Fearl	6059		
T is T	/	0	De col de v	70. Mailing /	Address (Street 2		Batto. T	or, City or Town, State, Zip) Code)
Important: If item 27 any injury or other tr once.	20a. Method o		170.043 1 CA	Place of Dispositi	ion (Maga of		Date	nd. 21213	
P P		2 ☐ Cremation 3 ☐ F		emetery, cremat	tory or other place	θ)	Date /	20c. Location - City or To	own, State
Jury		ion 5 □ Other (Specify)	- Louis	4View C	REMUTORY	1 1-9-	04	Ballo. Had.	
Important: Important: any injury o	21. Signatur	of Funeral Pervice Line	ee 0/1	22. N	Name and Addres	s of Facility	10 . 0	ilas is Dage	10000
5 = 3	14.	Malle	ell	741/				1639 N. BREG	away 21215
%	23a. Part1. Er shock, o	nter the disease, or complete heart failure. List only or	ications that caused the deat ne cause on each line.	h. Do not enter t	the mode of dying	g, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
sician	Immediate Ca	use (Final	MOTER A	SPURO	n D140	0000		4	Onset and Death
dical	resulting in de	ath)	Due to (or as a conseq		_				7 1011
niner			Respira	toRU	Failux	ee.			UKN
ğ 🚾	Sequentially li	st conditions, to immediate	Due to (u) as a conseq	and the second s		-			- 271
Examiner	cause. Enter Cause (Disease that initiated e	se or injury	•						
Exa	resulting in de	ath) Last	Due to (or as a conseq	uence of):					
e bur			d						
as th									
d by the attending physician and letached for use as the burial-transit.	IF FEMALE: 23b. Was dec	edent pregnant 2	3c. If yes, outcome of pregna					23d. Date of delive	erv
of for	in the par	st 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		ctopic pregnancy Other (specify)			Month	Day Year
detached Physic	9 ☐ Unkr		9□ Unknown						
deta /	Part II. Other s	ignificant conditions cor	ntributing to death but not res	ulting in the unde	erlying cause give	en in Part I.	23e. Did to	bacco use contribute to t	ne cause of death?
d by PI							1 🗆 Y	es 2 □ No 3 □ Prot	ably 4 Unknown
should							24. 146		
% S C C C	-						24a. Was autop	sy prior to co	psy findings available mpletion of cause of
Co Co							1 Yes	2 No 1 ☐ Yes	2 🗆 No
irector, page 2 s	25. Was case examiner?	referred to medical	Hospital: 🛶		100	26. Place of Deat	h (Check only o	ne)	
al dire	1 Tes	2000	1 Minpatient 2 □		3□ DOA Othe	4 🗆 Nursing Ho	ome 5 Resid	ence 6 Other (Specif	y)
Director: After the funeration by the funeration:	27. Manner of		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at c?	28d. Describe h	ow injury occurred	
or: A he tu	2 Accide	ent investigation			M 1 🗆 Y	res 2□No			
tiffic	3 ☐ Suicio		28e. Place of Injury - At he building, etc. (Specif	ome, farm, street	t, factory, office		28f. Location (S City or Tow	treet and Number or Rura n. State)	l Route Number,
al Director: After ited in by the funeral									
		1 Certifying Phys	sician: To the best of my kno	wledge, death or	ccurred at the tim	e, date and place,	and due to the o	ause(s) and manner as s	ated.
o the Funa empletely fill Medical	one)	/ Z Mouldai CX8MI	ner: On the basis of examina and manner stated.	and and of things	ouganon, in my op	milon, death occur	ed at the time, o	and place, and due to	ine cause(s)
To t	29b. Signature	and title of certifier			29c. License		- 2	29d. Date signed (Month,	Day, Year)
		5. Sodm			DH	2014		1-6-0	4
	30. Name and	address of person who co	ompleted cause of death (Item	n 23a) (Type, Pri	int)			1-6-0 PERRYT	bint Mid
7		INDEPAL	0 31-	M.D.	VANA	regland	Honly	h CARP	21007
State		(Month, Day, Year)	32. Registrar's igna				1 1 CCC	-1 -01170 6	31700

		7,1	,
	For Unpend	State of Maryland / Department of Health and Mental Hygiene Item #23a,27,28a-f per me G828 2/5/04 tas of Death Realth	
1-	State Orrpcrite	Trail 1/23a,21,20a-1 per lie Gozo Certificate of Death	

AK	-0197 G		1 - For Unpend It	em #23a	3,27,28a-f p	er me G8	S28 Cer	rtmeni Illicate	esof i	leaith and r Death	vientai Hy	giene Reg. No.	to me Van Sant	4 00	. Ju
	Physic	ian	Decedent's Name (First, I MICHAEL	Aiddle, Las	WHALEN	r					2. Date of De Month	Day			
	/Medi	cal	4a. Facility Name (If not insti					4h City	Town o	Location of Death	Janua		2004 County of Dec	7:15	<u>A</u> M
П	Exami	ner		_				_	_				ne Aru		
	Funeral	1	8425 Lockw 5. Social Security Number	6. Se		e (In yrs. last	birthday)	Pasa If Under	1 Year	If Under 24 Hrs.	8. Date of Bi		9. Bi	rtholace (State o	or Foreig
	Director		218-74-1697 Usual Residence of Decede		M 2□F	42	Yrs.	Months	Days	Hours Min.	8. Date of Bi (Month, Da March	04 1	961 Ma	aryland	
	Maryland -f show fied at	tor	10a. State 10b. Co	•	ındel Co.	10c. City, To	own or Loc saden							10d. Inside Ci	
	with the	Direc	10e. Street and Number 8425 Lockwoo	d Roa	nd			10f. Zip	Code 1122			_	zen of What C	Country?	
36	is 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Mudical Examinational be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ 3 □ Widowed 4 □ Divo	Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 XI If Yes, Give Year or Dates:			/as Deced Yes, spec		spanic Origin? (Sp n, Mexican, Puero Specify:	pecify Yes or No Rican, etc.))-	14. Race - Am Black, Wh Specify: W	ite, etc.	
2	72 hou natura	eted		edent's Ed	ucation	16	6a. Decede	ent's Usua	i Occupa	ation furing most of wor	kina	16b. Ki	nd of Business	s/Industry	
21215-0036	s within jiene. r then	Completed	Elementary/Secondary (0-		College (1-4or	5+)	Mecha		e retired	furing most of word)	9	Ove	rhead	Door Co.	
Maryland 2	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the M	To Be C	17. Father's Name (First, Min Lawrence	J.	Wha	alen Jr				18. Mother's Nam Virgin	. ,	_	Sumame) Srune	· · ·	
	1 and 2 shou Health and Mem 27 is maintent traumaintent		19a. Informant's Name/Reia Deborah A.							and Number or Ru					
saitimore,	0 0		20a. Method of Disposition 1 ☐ Burial 2 ☑ Crema 4 ☐ Donation 5 ☐ Oth				of Dispos stery, crem view	atory or ot	her plac		Date 09/2004		cation - City o		
Dail	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Se	Ze Licens	Kevin E	725		Name and	Addres Cul.	s of Facility Ly-Polyni Mountain	ak Fune	ral	Home p	.A.	2
	Physician /Medical Examiner	resulting in death) a. Due to (or as a consequence)					tion							Approximate Interval Betw Onset and D	e ween
		Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	1	b. — Due to for as	a consequenc	uence of:								
8/60,	icate be executed physicien and s the burial-transit	dical Exa	resulting in death) Last	l	Due to (or as	a consequenc	:e of):								
. Box e	USD STATE OF STATE O						Fetal death 3 □Ectopic pregnancy					23d. Date of delivery Month Day Yea			'ear
ras, r	Se Co	Part II. Other significant conditions contributing to death but not resulting											23e. Did tobacco use contribute to the cause of de		
		Completed											prior to death?	utopsy findings a completion of ca	
NICAL VICAL	Physician: Th this certificate ral director, pag	Be	25. Was case referred to me examiner?		Hospital:				0	26. Place of Deat	h Check on c	ne			
5	S S	은	1XXYes 2 ☐ No 27. Manner of Death		Hospital: 1 ☐ Inpatie		ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 State (Specify) At Scene 28b. Time of 28c. Injury at 28d. Describe how injury occurred					ene			
	Sing After fune	atlon	1 Natural 5 P	ending restigation	28a. Date of Inju (Month. Da 1/8/04	$\frac{Y^{\text{Pear}}}{1}$ 7:0	Objury	M	lc. Injury Work 1 🗆 Y	at ? ′es 2 X ⊡No	28d. Describe	iow injury	occurred		
5	3 ☐ Suicide 4 ☐ Homicide 6 ◯ Could not be determined 28e. Place of Injury · At home, building, etc. (Specify)							a et, factory,	office		unknown 28f. Location (S City or Tow Pasadena			ural Route Numb KWOOd Road	ď
	ely hos		29a. Certifier 1 Cer (Check only 2 Mac	ifying Phy ical Exami	rsician: To the best	of my knowled examination	lge, death o and/or inve	occurred a estigation,	t the tim in my op	e, date and place,	and due to the	cause(s)	and manner as	s stated. to the cause(s)	
	o the strict of	29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. Certifier 1 Certifying Physician: To the best of my kn can be considered and manner stated.							License	number		29d. Date	signed (Mont	h. Dev. Year)	

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

kSha L Zemus N.D.

113

31. Date filed (Month, Day, Year)

32. Registrar's Signature JAN 1 3 2004

111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.

JAnuary 9, 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Helen Mildred Yaeger Jan. 9 2004 5:40 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Futurecare at Cherrywood Baltimore Reisterstown If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🛣 F 212-09-4798 86 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Item 27 is marked other then "neturel", or items 23a or 28a-1 shov other treumatic event, the Mudical Examinar mant be radiified at 1 ☐ Yes 2 No Director Maryland Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 236 Walgrove Rd. 21136 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🗖 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Importent: If lenn 27 is marked other tren "ne any injury or other treumatic event and once. Elementary/Secondary (0-12) College (1-4or 5+) Book Keeper 8 Steel Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George C. Elliott Estelle Kirschnick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edna Bryant - sister 236 Walgrove Rd. Reisterstown, Md. 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Parkwood Cem. Jan. 12,2004 Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hote. Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills. Ella 23a. Pent1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Squentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 □Ectopic pregnancy for Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. I the th Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has certificate 2 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 1)27569 Greene Thee ted cause of death (Item 23a) (Type, Print) 30. Name and address of

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

2000

Funeral Director		ve street and numberyland Hossex			4b. City, To	our or			2. Date of Dea Month	eg. No. th Day	Year		3. Time of Death
Funeral Director	4a. Facility Name (If not institution, gradients) University of Ma 5. Social Security Number 6. 554-87-2028 Usual Residence of Decedent 10a. State 10b. County MD Anne Ar	ryland Hos	or) spital Age (In yrs. last			our of		(D	- 1			- 1	1:38 bi
Funeral Director	4a. Facility Name (If not institution, gradients) University of Ma 5. Social Security Number 6. 554-87-2028 Usual Residence of Decedent 10a. State 10b. County MD Anne Ar	ryland Hos	spital Age (In yrs. last	birthday)		Our 05		(Darah					
Funeral Director	5. Social Security Number 6. 554-87-2028 Usual Residence of Decedent 10a. State 10b. County MD Anne Ar	Sex 7.7	Age (In yrs. last	birthday)	0	OWII, OI	Location of	r Death		4c. (County of De	ath	
Funeral Director	5. Social Security Number 6. 554-87-2028 Usual Residence of Decedent 10a. State 10b. County MD Anne Ar	Sex 7.7	Age (In yrs. last	birthday)	13	ALT	IMOR	E			Baltim	ore	City
Funeral Director	Usual Residence of Decedent 10a. State 10b. County MD Anne Ar	21	19		If Under 1 Months		If Under 2 Hours	4 Hrs. Min.	8. Date of Birth			inthplac	e (State or Fore
Funeral Director	10a. State 10b. County MD Anne Ar			Yrs.	Months	Days	Hours	MIII.	B. Date of Birth (Month, Day Sep 29	1984	A CA	Country,	
Funeral	MD Anne Ar												
Funeral			10c. City, To	own or Loc	cation								Inside City Lim
Funeral	10e. Street and Number	undel	Sev	verna	Park								1 ☐ Yes 2 🔀
Funeral					10f. Zip C	Code			1	0g. Citiz	en of What (Country	?
	223 Ambleside Dr	ive				2114	6			Ţ	J.S.A.		
	11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U.S. s?	13. W	Vas Decede Yes, specif	ent of His	spanic Orig	in? (Spec	ify Yes or No- ican, etc.)	1	4. Race - An Black, Wh		
_	1 Never Married 2 Married	1 Tyes 2 F	₹ ^{No}		☐ Yes 2		Specify:				Canaiku		
0	3 Widowed 4 Divorced	Year or Dates	S:								specity.	whit	:e
ete	15. Decedent's l (Specify only highest g		10	(Give k	ent's Usual kind of work	done di	uring most	of working	,		d of Busines		•
g	Elementary/Secondary (0-12)	College (1-4o	or 5+)		OO NOT use						Diego		ıte
3				сотте	ge sti							У	
	17. Father's Name (First, Middle, Las	t)					18. Mother	's Name (First, Middle, I	Maiden S	Gumame)		
0	Richard Young						Cynt	hia	Hein				
	19a. Informant's Name/Relationship	(Type, Print)	1	19b. Mailing	g Address (Street a	nd Number	r or Rural	Route Number	City or	Town, State,	Zip Co	de)
1	Mrs. Cynthia Youn	g - mother	r 2	223 A	mbles:	ide	Drive	, Se	verna E	ark	MD 2	1146	; ;
1	20a. Method of Disposition	7D	come	of Dispos	sition (Name	e of ner place	,	Da	te	20c. Loc	ation - City o	r Town	State
J	1 X Burial 2 □ Cremation 3 1 4 □ Donation 5 ☑ Other (Spec	⊔Hemovai from Stat ify)	(0	•			.	n 10	, 2004	Gler	n Burn	ie,	MD
1	The second second	4											
	Velin	2-1	no13/	9 1	Secon	d Av	enue	S.W.	. Glen	Buri	nie. M	D 21	061
\forall	23a. Part1. Enter the disease, or cor	nplications that caus	ed the death. D	•						_		Ar	proximate
												Int Or	erval Between iset and Death
	disease or condition												
		Due to (or a											
	Sequentially list conditions,	0,	AL LI	NCED	HALL	TIS							
	cause. Enter Underlying Cause (Disease or injury	200 (3, 0	25 & 601 5046011	ou oi).								ì	
xau	that initiated events resulting in death) Last	c. Due to (or a	as a consequenc	ce of):	_							-	
		020 (0 (0)		30 3.7.								1	
Š	•	d											
Me	IF FEMALE:	-0. 11	,	110					- 111			1	
an/	23b. Was decedent pregnant	1☐Live birth	2 Fetal dea	ath 3 □E						23		-	v Year
200	1 ☐ Yes 2 No			5 🗆	Other (spec	cify)					WORK	Da	1001
5										+			
	Part II. Other significant conditions	contributing to death	but not resulting	g in the un	derlying cau	nse give	n in Part I.		23e. Did tob	acco us	e contribute	to the c	ause of death?
e G									1 □ Ye	s 2	(No 3□F	robably	/ 4 □Unknov
Set											24b. Were a	utopsy	findings availat
Ē									perform	ned?	death?		
٠.	25. Was case referred to medical	_					OS Diana	of Dooth /	1	!	1 U Y 0	s 28	No
מ	examiner?	Hospital:	tiont 0 0 50/	·	a□ 204	Other	-						
- 1		-			-		4 Nur					ecity)	
9	1 Natural 5 ☐ Pending	(Month, E	Day Year)	Injury	1	Work'	?		a. 20001100 110	w many	00001100		
2	3 Suicide 6 Could not	De Place of I	niury - At home	farm stre					f Location (St	reat and	Number of F	Dural Pa	uta Numbor
	4 Homicide determined	building,	etc. (Specify)	, iaim, sile	et, lactory, t	Office		20			radiniber of F	iurar no	ute radiliber,
								1					
ca Ca	(Check only 2 Medical Exa	miner: On the basis	of examination	dge, death and/or inve	occurred at estigation, ir	the time n my opi	e, date and inion, death	place, an occurred	d due to the ca Lat the time, da	iuse(s) a ite and p	nd manner a place, and du	s stated e to the	i. cause(s)
Jed -	one)	and manner:	stated.										
-	29b. Signature and title of certifier	111			29c. l	License	number		2				, rear)
	7 Coherte	Cerl Mi)			15	167			01	106/0	14	
	30. Name and address of person who				,							-	
	Dr. Robert E. Re	if 22 S.	Green	Stree	et, I	Balt	imore	, Ma	aryland	21	201		
Contract to the Contract to th	hysician/Medical Examiner	17. Father's Name (First, Middle, Las Richard Young 19a. Informant's Name/Relationship Mrs. Cynthia Youn 20a. Method of Disposition 1	Richard Young 19a. Informant's Name/Relationship (Type, Print) Mrs. Cynthia Young — mothe: 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signaturated fun a Service Licensee 23a. Parl 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause or injury that initiated events resulting in death) Last Due to (or a d. Due to	17. Father's Name (First, Middle, Last) Richard Young Richard Young 19a. Informant's Name/Relationship (Type, Print)	17. Father's Name (First, Middle, Last) Richard Young 19b. Mailin Mrs. Cynthia Young - mother 20b. Place of Disposition 12 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition 12 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition 12 Burial 2 Cremation 5 Other (Specify) 21. Signaturacy Fun at Service Learner 22b. Place of Disposition 12 Burial 2 25b. Place of Disposition 25b. Place of Disposition 12 Burial 2 25b. Place of Disposition 25b. Place Of Disposition 25b. Place Of Disposition 25b. Place Of Disposition 25b. Place Of Disposition 25b. Place Of Disposition 25b. Place Of Disposition 25b. Place Of Disposition 25b. Place Of Disposition 25b. Place Of Disposition 25b. Place Of Disposition 25b. Place Of Disposition 25b. Place Of Disposi	T. Father's Name (First, Middle, Last) T. Father's Name (First, Middle, Last)	Richard Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street a 22.3 Ambleside 220. Method of Disposition 12 Burial 2 Cremation 3 Removal from State 20a. Method of Disposition 12 Burial 2 Cremation 3 Removal from State 22. Name and Address (Street a 22. Name and Address of person who completed cause of death (Item 23a) (Type, Print) Dr. Robert E. Reif 22 S. Green Street, Balt	Richard Young 19a. Informant's Name (First, Middle, Last) 18. Mother 19b. Mailing Address (Street and Number 223. Ambleside Drive 220a. Method of Disposition 17c Burial 2 2 Cremation 17c Burial 2 2 Cr	Richard Young Richard Young 18. Meliher's Name	Richard Young — mother 20. Richard Young — mother 20. Method of Disposition 1.2 Lindraghts Name (First, Modile, Last) Mrs. Cynthia Young — mother 20. Method of Disposition 1.2 Lindraghts 2 Crempton 3 Removal from State 1.3 Lindraghts 2 Crempton 3 Removal from State 1.4 Lindraghts 2 Crempton 3 Removal from State 1.5 Lindraghts 2 Crempton 3 Removal from State 1.6 Lindraghts 2 Crempton 3 Removal from State 1.7 Lindraghts 2 Crempton 3 Removal from State 1.8 Mother of Name (First, Model) 223 Ambleside Drive, Severna F 224 Ambleside Drive, Severna F 225 Lindraghts 2 Crempton 3 Removal from State 226 Lindraghts 3 Removal from State 227 Lindraghts 3 Removal from State 228 Lindraghts 3 Removal from State 229 Lindraghts 3 Removal from State 229 Lindraghts 3 Removal from State 230 Lindraghts 3 Removal from State 231 Lindraghts 3 Removal from State 232 Lindraghts 3 Removal from State 233 Lindraghts 3 Removal from State 234 Lindraghts 3 Removal from State 235 Lindraghts 3 Removal from State 236 Lindraghts 3 Removal from State 237 Lindraghts 3 Removal from State 238 Lindraghts 3 Removal from State 239 Lindraghts 3 Removal from State 240 Lindraghts 3 Removal from State 241 Lindraghts 3 Removal from State 242 Lindraghts 3 Removal from State 243 Lindraghts 3 Removal from State 244 Lindraghts 3 Removal from State 245 Lindraghts 3 Removal from State 246 Lindraghts 3 Removal from State 247 Lindraghts 3 Removal from State 248 Lindraghts 3 Removal from State 249 Lindraghts 3 Removal from State 240 Lindraghts 3 Removal from State 240 Lindraghts 3 Removal from State 241 Lindraghts 3 Removal from State 242 Lindraghts 3 Removal from State 243 Lindraghts 3 Removal from State 244 Lindraghts 3 Removal from State 245 Lindraghts 3 Removal from State 246 Lindraghts 3 Removal from State 247 Lindraghts 3 Removal from State 248 Lindraghts 3 Removal from State 249 Lindraghts 3 Removal from State 2	Richard Young 13a. Informant's Name/Folationship (Type, Print) 13b. Mailing Address (Street and Number or Parts Route Number, City or Mrs. Cynthia Young – mother 12a. Method of Deposition 12b. Mailing Address (Street and Number or Parts Route Number, City or Mrs. Cynthia Young – mother 12b. Method of Deposition 12c. Local Comments (Parts, Medide, Mealing Address)	Richard Young Richard Route Number of Paula Route Number. City or Town, State, 220. Place of Disposition (Name of Young Paula) Richard Young Richard Young Richard Young Richard Young Richard Young Richard Young Richard Young Richard Young Richard Young Richard Route Number, City or Town, State, 200. Place of Disposition (Name of Young Paula) Richard Route Number, City or Town, State, 200. Place of Disposition (Name of Young Paula) Richard Young Richard Young Richard Young Date 200. Place of Disposition (Name of Young Paula) Richard Young Richard Young Park Jan 10, 2004 Glen Burni Richard Route Number, City or Town, State, 200. Place of Disposition (Name of Young Paula) Richard Young Richard Young Park Jan 10, 2004 Richard Young Richard Young Richard Young Park Jan 10, 2004 Richard Young Ri	Richard Young 18. Informaria Nama (Pirst, Modile, Last) Richard Young 19. Mailing Address (Sizeet and Number or Plural Route Number, City or Town, State, Zip Co. Mrs. Cynthia Young — mother 20. Named Disposition 19. Mailing Address (Sizeet and Number or Plural Route Number, City or Town, State, Zip Co. 21. Segulated Disposition 19. Mailing Address (Sizeet and Number or Plural Route Number, City or Town, State, Zip Co. 22. Name and Address of Pacility 23. Segulation of Disposition (Sizeet) 23. Segulation of Disposition (Sizeet) 23. Segulation of Disposition (Sizeet) 23. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 23. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 23. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 23. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 23. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 23. Due to (or as a consequence of): 23. Due to (or as a consequence of): 24. Was a cause (Final Liberty) 25. Was deceded priggnant in time of death by City or Completed in the cause of the cause of death or cause of the caus

				ype or Print in State of Maryla				-		
7			1 - For State Registrar	,		rtificate of		Re	g. No.	. 0000.
	Physic /Medi		1. Decedent's Name (First, Middle, Last) Edwin G. Zi	mmerman, J	r.			2. Date of Deatl Month	Day Hoar	3. Time of Death + 5:057 M
	Examir	ner	4a. Fecility Name (If not institution, give s	del Hosp	(عرزم	6 m	Cocation of Death	32	4c. County of Dea	Armda)
	Funeral Director		5. Social Security Number 218-10-4309 Usual Residence of Decedent	7. Age (in yrs 84	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, NOV 22,	Year) 9. Bir 1919 Mar	thplace (Stete or Foreign ountry) y Land
	Maryland	tor	10a. State 10b. County Maryland Anne Arur		ity, Town or Lo en Buri					10d. tnside City Limits 1 ☐ Yes 2 ☐ No
	th with the 23a or 28	Funeral Director	10e. Street and Number 6503 Home Water W			10f. Zip Code 21060			g. Citizen of What Co JSA	ountry?
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinal manages and political at	þ	11. Marital Status 1 1 Never Married 2 Married 3 Widowed 4 Divorced		1/. 2	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
215-0	rithin 72 ho ne. han "natur Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation	16a. Decec (Give life. L		during most of worki d)	ng	6b. Kind of Business	/Industry
Maryland 21	I be filed with ntal Hygiene. ed other than event, the M	Be	12 17. Father's Name (First, Middle, Last)		Lautiu	ry Manage	18. Mother's Name	(First, Middle, M	·	i 5-
2	2 should be and Mental I is marked o	2	Edwin G. Zimmerma 19a. Informant's Name/Relationship (Typ		19b. Mailin	na Address (Street	Elsie M.		City or Town, State,	Zin Code)
a,	Pages 1 and 2 nent of Health a int: If Item 27 is iry or other trait		Edna Marie Zimmern 20a. Method of Disposition 1 Surial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	amoval from State Gar	6503 Place of Dispo cemetery, cren rison Fo	Home Wat sition (Name of natory or other place rest	er Way #2	04 Gler ate 2	Burnie, Oc. Location - City or Dwings Mil	11) 21060 Town, State
	permit. Pages Department of Importent: If it any injury or conce.		21. Signature of Funeral Service License Thomas Gregor	9	Ma	Name and Address Rush Rush		e. P.A.	ville. MD	
	Physician /Medical Examiner		23a. Pert1. Enter the disease, or complic shock, or heart failure. List only one Immediete Cause (Final disease or condition resulting in death)	ations that caused the dea	th. Do not ente			r respiratory arres	retry	Approximate Interval Between Onset and Death
	e be executed /sician and e burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a onsec		× (1)	6			
	cate be e physician s the buris	m	d.					·		
	that the death certificate led by tha attending physi detached for use as the l	Physiclan/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of pregn 1 Live birth 2 Fete 4 Pregnant at time of c 9 Unknown	al déath 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
ecords, P	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions cont	ributing to death but not res	sulting in the un	nderlying cause givi	en in Part I.		cco use contribute to	the cause of death?
Ì	The ate ha	Completed						24a. Was an autopsy performi	prior to d	atopsy findings available completion of cause of
VItal	Physician: rthis certifica ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	I EDIO	2□ DOA Oth	26. Place of Death			
VISION OF	After	-	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Work	4 Inursing Hon	ne 5∐ Residen 8d. Describe how	ce 6 Other (Spec	city)
-	o # 5 ⊑	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specia	ome, farm, stre	eet, factory, office	2	8f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
1	ne Acspitel n 24 hours a he Funerel I pletely filled	edical (29a. Certifier (Check only one) Check only one)	cian: To the best of my kno er: On the basis of examina and manner stated.	owledge, death ation and/or inv	occurred at the time restigation, in my op	ne, date and place, a pinion, death occurre	nd due to the cau d at the time, dat	se(s) and manner as e and place, and due	stated. to the cause(s)
	vithin 2 To the	Σ	29b. Signatur in title of ce ifier	-1 ms		29c. License	number	290 Des	Date signed (Month	1. Day, Year)
K	0		KOFI BOVAT	Ty/ 3V	المرار (المرار)	ا در در در در در در در در در در در در در	1 Bv.,	(7/200	Brim	1, mo 210H
4	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's Signa	ature	م محمد				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Zo11 January 2004 Gilbert 10, Kenneth /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth **Examiner** Baltimore
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yeer) 243 West Medwick Garth Baltimore 7. Age (In yrs. last birthday) 5. Social Security Number Birthplece (State or Foreign Country) **Funeral** 1 □ M 2 □ F 81 Director 212-12-5188 March 15, 1922 Maryland Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location rel', or Items 23a or 28a-f ehow Examiner must be notified at 1 Yes 2 No Maryland Baltimore Baltimore Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death 1 Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other then "naturel", or Items 23 any Injury or other treumatic event, the Medical Examiner must any Dings. 243 West Medwick Garth 21228 by Funeral USA 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ZYes 2 No If Yes, Give Year or Dates: WW II 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pipemaker Sheet Metal Company Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mabe1 Clay D, ZollJones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2637 Gillis Rd., Mt. Airy, MD 21771 Patricia E. McGee (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 1/14/04 Baltimore, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician POXIA /Medical Due to (or as e consequence of) **Examiner** HYPERLAPNIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit SEVERE resulting in death) Last Due to (or as a consequence of) Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for P.O. 1 Yes 2 No Part fl. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by MITRAL REGURGITATION 2 □No 3 ☐ Probably 4 ☐ Unknown been sig HTYes CARDIOMYOPATHY 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has I autopsy 1 Yes 2 DING or Attending Physicien: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Stresidence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: After Naturat 5 Pending investigation i hours after death.
uneral Director: A death. 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours af To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 050303 0 0

DHMH 17 Rev 1/2001

State Registrar

21215-0036

Baltimore, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra Signature

aiden

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 💹 🕠 🗓 👢 State Registrar AMEND ITEM #2 PER DVR G827 1/13/04 Seprificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2004 **Physician** 4, 2003 GENEVIEVE L. ZAMERSKI JAN3:45 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 1205 DELBERT AVE. BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F 88 11/19/15 Director 212-07-9206 MARYLAND Usual Residence of Decedent 10d. fnside City Limits 10a. State 10b. County 10c. City, Town or Location or 28e-f show other treumatic event, the Medical Examiner must be notified at 1 Tyes 2 No Director BALTIMORE BALTIMORE 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21222 USA 238 1205 DELBERT AVE. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 ŏ 1 Yes 2 No Specify: þ Year or Dates: 3 ☑ Widowed 4 ☐ Divorced WHITE natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuaf Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) GROCERY STORE 10 0 OWNER other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental f Health and Menta item 27 is marked HEDWIG GODLEWSKI STANISLAUS LISZEWSKI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MISS GERTRUDE FELKOSKI 1205 DELBERT AVE. BALTIMORE, MD. 21222 Baltimore, Important: If iten any injury or othe once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ⊠Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) HOLY ROSARY CEME. 1/7/04 DUNDALK, MARYLAND 21. Signature of Funeral Service L KACZOROWSKI TUNERAL HOME P.A. Cartne DUNDALK AVE. BALTIMORE, MD. 23a. Part1. Enjor the disease, or com shock, or heart failure. List only mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. Immediate Cause (Final disease or condition Heart Disease **Physician** resulting in death) /Medical Examiner therosa Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): 68760 attending physician for use as the buris Physiclan/Medical as the Box (IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of defivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.O. 1 detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by page 2 should be 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown peen mingioma (Brain) 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed arlangins 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending 1 Natural 1 Yes 2 No death. investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Dire 4 Homicide filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 01/06/2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LORRES, MO. 441 S. ELLWOOD AU; BALTOMO 21224 MELITO 32. Registrar's Senature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrat 1-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 6:00FM 01 03 04 /Medical Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death. Examiner tsal1/ 1.10 8. Date of Birth (Month, Day If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last brithday) Birthplace (State or Foreign Country) Funeral Months M 2 F Days Hours -36 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show 7 is marked other than "neturel", or Items 23a or 28e-f sho treumetic event, tha Medical Examinar must be notified at Yes 2 No Director 01 10f. Zip Code 10g. Citizen of What Country Wa Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes Give
Year or Dates: Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 0 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. lal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ,4 me na ပ 19b. Mailing Address (Street and Number or Rural Route Number, C. Town, State, Zip Code) Department of Health Importent: If item 27 Wa 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 Removal from State Drestil 21. Signature of Furferal Service License 22. Name and Address of Facility we 12/70 600 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate In erval Between Onset and Death Immediate Cause (Final Q bsis Physician Cost disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Moonic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): 6876¢ Physiclan/Medical or Attending Physicien: The law requires that the death certificated IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No page 2 s autopsy performed this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 🗀 Pendina 1 Yes 2 No hours after death. 2 Accident investigation filled in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗀 Homicide To the Hospitel within 24 hours a Medical 29a. Certifier 🕪 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mehta M! 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore 21230

DHMH 17 Rev 1/2001

State

Registrar

Res

JAN 1 3 2004

31. Date filed (Month, Day, Year)

601

TA,MD

32. Registrar's Signature

South

	•	For State Registrar	State of M	aryland		rtmen tificate			and M	ental Hyg	iene 19. No.	Ł	50.866
		Decedent's Name (First, Middle, Last)								2. Date of Deat Month	h Day	Yeer	3. Time of Death
Physicia		Mi	chael Z	Zaetz	Jr.					Jan	10	2004	8-50 AM,
/Medic Examin	_	4e. Fecility Name (If not institution, give stre	et and number,)				Location o				inty of Death	
L. Admini	•	ST-AGNES HEAL	TH C.A	RE			BA	LTIN		E	1	N/A	
Funeral Director		5. Social Security Number 6. Sex 129 10 9971	7. A	ge (in yrs. i. 77	ast birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, July 23	, 192	Cour	plece (State or Foreign htry) yland
P.		Usual Residence of Decedent 10a. State 10b. County		10c Cib	. Town or Lo	cation							Od. Inside City Limits
arylar show	-		n d o 1	,	inthic								1 ☐ Yes 2 No
86-f	Director	Maryland Anne Aru	nası		Indite	10f. Zip	Codo			1	On Citizen	of What Cour	ntry?
s after death with the Marylan s of teme 23e or 28e-f show tacified must be notified at		10e. Street and Number 711 Greentree Roa	d			101. 2.10	2109	90			-	S.A.	•
s 23	era		Was Decedent	Ever in U	S. 13. V	Was Deced	lent of His	spanic Orie	gin? (Spe	city Yes or No-	14.	Race - Americ	can Indian,
Item Item	Funeral	11. Marital Status 1 Never Married 2 Married	Armed Forces 1 XYes 2 □	?	1					city Yes or No- Rican, etc.)		Black, White,	
urs at	þ	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes	2 X No	Specify:			Spe	ecify: Wh	ite
filed within 72 hours after death with the Maryland Hygiene Hygiene Hygiene Hygiene with than "natural", or Items 23s or 28s-1 show ant, the Movical Exacula or matter notified and	ted	15. Decedent's Educa (Specify only highest grade of	tion		16a. Decec	ient's Usua kind of wo	I Occupa	ition	t of worki		16b. Kind o	of Business/In	dustry
thin 7	ple	Elementary/Secondary (0-12)	College (1-4or	5+)	life. L	DO NOT us	e retired,)			Lon	cabara	m¬n
od wil	Completed	12th			Che	cker		40.11.15	1. 1.	(Fi 14:22) - 1		gshore	man
be filed within 72 hatal Hygiene. Id other than "natu	Be (17. Father's Name (First, Middle, Last)		C						(First, Middle, M		vailab:	19)
	٩	Michael 2		Sr.	105 14-11-	- 4	(Ctroot o		ary	I Route Number			- 111
d 2 should th and Mer 7 is marke traumatic		19a. Informant's Name/Relationship (Type		7	909				_				yland 21146
1 and Health ern 27 ther to		Steven E. Zaetz /	перпеч	20b. P	lace of Dispo	sition (Nar	ne of					on - City or To	
Pages nent of int: If its		1 ☐ Burial 2 ☐ Cremation 3 ☐ Ren	noval from State	9 (emetery, crem /view (-			1/12/	/2004	Balti	more,	Maryland
it. Partmer		 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 		, Day				1					Home, P.A.
permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra		ISMAN DA	XV	1ge	th 4	001 F	litch	nie H	ighwa	ay Balt	imore	Mary	land 21225
	-	23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one	tions that cause	on the death									Approximate Interval Between
Physician		Immediate Cause (Final	HEPA						_				MON7HS
/Medical		disease or condition resulting in death)	Due to (or a	s a conseq	uence of):			7 01	1				
Examiner		Sequentially list conditions b.	ALCOR	IDLI	0 01	RRH	031	5 0	FL	IVER			
Was a	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequ	uence of):								
acute ind trans	Examiner	Cause (Diseese or injury that initiated events c. resulting in death) Last	Due to (or a		vance of):						-		
ate be executed hysician and the burial-transit		Todaking in dodain, cast	D00 10 (01 a	s a consequ	derice on.								
cate l	dical	d.											
vequires that the death certifica vequires that the death certifica been signed by the attending phatouid be detached for use as the	Physician/Med	IF FEMALE: 230	. If yes, outcom	e of pregna	incy						23d.	Date of delive	ery
atten	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant]Ectopic p]Other <i>(s</i> p						Month	Day Year
the d	ysi	9 Unknown	9□ Unknown										
s that	by PI	Part II. Other significant conditions conti							l.	23e. Did tot	acco use	contribute to t	he cause of death?
w requires (HISTORY OF POR	TAL Y	EIN	7/16	20M	80≤	315		1 ☐ Ye	s 2181N	o 3 Prot	oably 4 Unknown
s been si	plet									24a. Was a autops		4b. Were auto	opsy findings available impletion of cause of
Figure 1 Vica mode fending Physician: The lav leath. for: After this certificate has the funeral director, page 2	Completed									perform	ned?	death? 1 ☐ Yes	
ician: centifica	Be C	25. Was case referred to medical					-			Check on on			
Physic Physic this ce	10	examiner? 1 ☐ Yes 2 🔀 No	spital: 1KInpa		ER/Outpatier					me 5 Reside			fy)
ng Pl	on:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of In (Month, D	jury ay Year)	28b. Time of Injury		8c. Injun Work			28d. Describe ho	w injury o	curred	
Attending or death.	catl	2 Accident investigation 3 Suicide 6 Could not be	22 Plan 41	-i As b		M		Yes 2		28f Location (St	reet and N	umber or Ruc	al Route Number,
or Att	Certification:	4 Homicide determined	28e. Place of I building,	etc. (Specif	y)	reet, tactor	у, опісе			City or Town	n, State)	amber of Hari	a riodie rumber,
To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the	edical Co	29a. Certifier 158 Certifying Physi (Check only 2 Medical Exemine	cian; To the best er: On the basis and manner:	of examina	wledge, deat tion and/or in	h occurred vestigation	at the tin	ne, date ar pinion, dea	nd place, a ath occurr	and due to the ca ed at the time, d	ause(s) and ate and pla	d manner as s ice, and due t	stated. o the cause(s)
thin 2 the mple	Med	29b. Signature and title of certifier	and mainer:	oración.				e number				gned (Month,	
Z × Z		MReyeamach	M	yr.	M.D	-A	9-3	1438	152	8	Jan-	10-2	004
~				death (Iten	n 23a) (Type.	Print)	TV:54		D.C. :	ATTO - A	vec e	Azera	120 000
W'		30. Name and address of person who con WIRUF AMA D-MITI	KIRI, ST	VCINE	SHEF	96777	CAR	E, 7	TU C	AICN A	VIE , L	PACTION	21229
Sta	ite	31. Date filed (Month, Day, Year)	32 Regis	strar's Signa	ture								
Regist	rar	IAN 1 3 2004	14	h	Con	2/2							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 200 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Physician 2:00 Am Helen Armetta JANUARY 2004 /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City Stella Maris Hospice at Mercy Hospital Baltimore 8. Date of Birth Month, Day, Year, Dec 0, 1924 Birthplace (State or Foreign County) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex **Funeral** Months Deys Hours 1□ M 2∏ F 79 212-22-8319 Director Usuel Residence of Decedent 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Location parmit. Peges i and 2 should be filed within 72 hours after daath with the Maryler Dapartment of Haaith and Mental Hygiene. Important: If itam 27 is marked other than "natural," or heme 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notfiled. 1 ☐ Yes 2 ☑ No MD Carrol1 Sykesville Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21784 317 Kingston Circle USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White Be Completed by 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Domestic 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Armetta Stefanina Muffoletto 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr. Michael Armetta (Nephew) 1515 Green Mill Rd., Finksburg, MD 21048 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Gardens of Faith Cemetery 1/15/04 Baltimore, MD 1 D Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Puneral Service Licenses HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of such line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 00 Lancel Examiner Due to (or es a consequence of): Physician/Medical Examiner attending physicien and for use es the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 1 Yes 2 No edical Certification; To Other (Specify) 28c. Injury at Work? 28d. Describe how mjury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 1 Neturel 5 Pending 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

or Attending Physician: The law requires that the daath certificate be axecuted Hospital

within 24 hours after death.

To the Funeral Director: After completely filled in by the funer

DHMH 16 Rev 6/95

State Registrar

31. Date filed (Month, Day, Year) JAN 1 4 2004

29b. Signature and title of certifier

(Check only

Rusebern 32. Registrer's Signeture

54

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29c. License number

Paul Pl.

40854

29d. Date signed (Month, Day, Year)

Baltimer

2004

21200

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

501

			1 - For State Registrar AMEND ITEM #5	State of Mary PER INF G829 3					and M	lental Hy	giene Reg. No.2	04	00608	
Physician			1. Decedent's Name (First, Middle, Last)						2. Date of Death Month Day Year 3. Time			3. Time of Death		
/Medica			LAURA	ANTO	TOLIK January						2004	1843 M		
Examine		er	4a. Facility Name (If not institution, give		4b. City, Town, or Location ot Death					4c. County of Death				
			St. Hypes F	Kaltha	re	10	Uti	me	ore	2				
	Funeral		5. Social Security Number 6. Set	XP37-	yrs. last birthday) 85 Yrs.	It Under Months		If Under:	Min.	8. Date of Bir (Month, Da 2/4/19	th Iv. Year)	9. Birth	place (State or Foreign intry) NSYLVANIA	
	Director		Usuel Residence of Decedent		رو					2/4/19	910	PEN.	NSYLVANIA	
	land ow		10a. State 10b. County	100	c. City, Town or Lo	cation							10d. Inside City Limits	
	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-1 ahow other traumatic event, the Medical Examinar must be notified at	to	OH CUYAHOGA CLEVELAND										XXYes 2□No	
		rec	10e. Street and Number 10f. Zip Code								10g. Citizen o	f What Cou	intry?	
		a D	16713 WESTDALE AVENUE 44135							U.S.A.				
		Funeral Director	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	13. Was Decedent of Hispanic Origin? (Spit Yes, specify Cuban, Mexican, Puerto				ecify Yes or No)- 14. R	. Race - American Indian, Black, White, etc.		
9		Fu	1 Never Married 2 Married	1 ☐ Yes 2\1\1\1\No It Yes, Give	1	1 ☐ Yes XX No Specity:			, rueno	nicari, etc.)		Specify: WHITE		
5-0036		To Be Completed by	3 XXidowed 4 □ Divorced	Year or Dates:							Spec	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
5			15. Decedent's Edu (Specify only highest grade	cation co <i>mpleted)</i>	16a. Dece (Give	dent's Usual Occupation kind of work done during most of workin DO NDT use retired)				ng 16b. Kind of Business/Indu			ndustry	
2121			Elementary/Secondary (0-12) College (1-4or 5+) NURSING SUPERVISOR							HOSPITAL				
0										ne (First, Middle, Maiden Surname)				
an			PHILLIPIO CIAMACO	CA						MARCHIO				
Maryland			19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailir	ng Address	(Street a	nd Numbe	r or Rura	Il Route Numb	er, City or Tow	n. State. Zir	c Code)	
<u>×</u>	alth ar 27 is 1r trau		SOLLY CIAMACCA								ORE, M			
ē,	permit. Pages 1 a Department of Hea Important: If item any Injury or othe		20a. Method of Disposition		0b. Place of Dispo cemetery, crer	sition (Nan	ne of	1	C	ate	20c. Location	- City or T	own, State	
Baltimore			1 XXurial 2 ☐ Cremation 3(XYP) 4 ☐ Donation 5 ☐ Other (Specify)	emoval trom State						5/2004 NORTH OLI			ISTED, OH	
alt:			21. Signature of Funeral Service License	00	22	. Name an	d Address	s ot Facility	/ F	INK FUN	NERAL H	OME.	PA	
m			KELLY GREGORY FINK #M01148 426 CRAIN HWY, S, GLEN BURNIE, MD 21061											
	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between											
Y		1	Immediate Cause (Final disease or condition Acute Respiratory Failure Onset and Death											
		Ì	resulting in death) a. Due to (or as a consequence ot):							4 clays				
	Examiner		Sequentially liet conditions & ASDINATION PRELIMONIA 4 days								4 days			
	יי ק	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to/(or as a cor	nsequence of):								7	
h	executed in and ial-transit	(am	that initiated events resulting in death) Last											
			Totaling in doubly Educ	Due to (or as a cor	rsequence ot):									
876	physi the t	dicai												
9 X	leath certifica attending ph I for use as th	Physician/Med	IF FEMALE:	3c. If yes, outcome of pro	egnancy									
Вох	atten for u	cian	in the past 1/2 months?	1 Live birth 2 1	1 Live birth 2 ☐ Fetal death 3 ☐			Ectopic pregnancy				23d. Date of delivery Month Day Year		
o.	law requires that the death certificate be as been signed by the attending physicia 2 should be detached for use as the bur	ysi	1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)											
٩			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death?			
Records,	quires n sign	d by								1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown				
000	w requir been si should	Completed								24a. Was an 24b. Were autopsy findings av.			onsy findings available	
ď	The lav	E								autopsy prior to completion of cause of death?			mpletion of cause of	
Vital	ician: Th certificate rector, pag	BeC	25. Was case reterred to medical					26 Place	of Death		2 No	1 🗆 Yes	2□ No	
>	Physician: r this certific ral director,	To B	examiner?	26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)										
o t	ding After fune	2	27. Manner of Death	28a. Date of Injury (Month, Day Yea	28b. Time of		28c. Injury at Work?				8d. Describe how injury occur			
Ö		atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(WORLI, Day 16a	(r) Injury			res 2□No						
Division	r Atte er de recto by th	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify)					28f. Location (S	Street and Num	ber or Rura	al Route Number,		
	talor Arsatter al Directed in by	Cer							City or Town, State)					
	To the Hospital or Attenwithin 24 hours after deall To the Funeral Director: completely filled in by the		29a. Certifier (Check only 2 Medical Examin	ician: To the best of my ler: On the basis of exar	knowledge, death	occurred a	at the time	, date and	place, a	and due to the	cause(s) and m	anner as s	tated.	
	the H 1 24 the F The F	Medical	one)	and manner stated.					10000110					
	To To	4	29b. Signature and title of certifier	29c. License number					,	29d. Date signed (Month, Day, Year)				
		(Saine) /	Daton Ave Baltimore MD 2						10,2004				
	10		30. Name and address of person who co		(Item 23a) (Type, I	Print)	0	4.0	R	n Him	nc-	111	7/279	
	1		31. Date tiled (Mansha Ray, Year) 200	Registrar's S	ignature	MIN	1/	NE	1	0111111	ure, 1	VIV	2120/	
	Sta Registr		JAN '1 4' 2004	The gues	Jr And	ALL D								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Deeth Month Day Leon Armstrong Year **Physician** Thomas January 6:55 AM 2004 /Medical 4b. CitynTown, or Location of Death 4a Fecility Neme (If not institution, give street and number, 4c. County of Death Examiner Himore 31 Himore Under 24 Hrs. If Under 1 Year Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1⊠M 2□F Director 213-03-1917 86 AUG. 17, 1917 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 11 Yes 2 □ No Directo MD NA BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 1917 PENROSE AVE 21223 1st. FL. USA Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Yes 2 □ No 1942 If Yes, Give AFRICAN 1 ☐ Yes 2 No Specify: Specify: Completed by 3 Widowed 4 Divorced Year or Dates: 1946 AMERICAN Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 SHOREMAN LABORER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) **JAMES** ARMSTRONG BURL ARMSTRONG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARNETT (COMPANION) 1917 PENROSE BALTIMORE, MD MATILDA AVENUE 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ABurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST VET. CEM 1/21/04 OWINGS MILLS, MD 21. Signature o meral Service icensee 22. Name and Address of Facility WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 21217 2.a. Part1. Enter the dise 1..., or comshock, or heart failure. List only to caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest on each line. Approximate Interval Between Onset and Death Physician meningioma Immediate Cause (Final disease or condition resulting in death) /Medical 12 months Examiner Due to (or es e consequence of): Examiner attending physician and for usa as the bunal-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown \$ 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Completed 1 Yes 2 PNo 1 ☐ Yes 2 ☑ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral 28b. Time of Injury 27. Manner of Death . Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1. Natural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 Wasan, MD AU4176435W15140 January 13, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) JAN 1 4 2004 Registrar

			For State	State of Ma	ryland / De	epartment of I	Health and M	7	_	ה טטפוט ה
_			Registrar		(Certificate of	Death		Reg. No.	7 00010
	Physici	20	Decedent's Name (First, Middle, Last					2. Date of Dea	Day Ye	3. Time of Death
	/Medic		Mary	Dasch		Bell		Janua		10:1-
	Examin	er	4a. Facility Name (If not institution, give	street and number)		4b. City, Town,	or Location of Death		4c. County of D	eeth
			North Arundel H				Burnie	1	Anne A	
	Funeral		5. Social Security Number 6. S	ex	(In yrs. last birthe	Months Davs		8. Date of Birtl (Month, Day	Year) 9.	Birthplace (State or Foreign Country)
	Director		217-10-1342	- · · - X	80 Yr	5.		July 28	3, 1923	Baltimore, MD
	and w		Usual Residence of Decedent 10a. State 10b. County	1	10c. City, Town o	or Location				10d. Inside City Limits
	Aanyl f sho	5	MD Anne Ar	undol	M+11	ersville				1 ☐ Yes 2 🔀 No
	28e-	ect	10e, Street and Number	ander	LITTI	10f. Zip Code			10g. Citizen of What	Country?
	with a or	<u>=</u>	1181 Tanager Dr.	i 170			21108		USA	,
	death with the Maryland ms 23a or 28e-f show r nust be notified at	by Funeral Director	11. Marital Status	12. Was Decedent E	ver in U.S.	13. Was Decedent of If Yes, specify Cub		ecify Yes or No-		merican Indian,
40	iter of the control o	돌	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 □Yes 2 X XN				Rican, etc.)	Black, V	/hite, etc.
036	urs a	þ	3€Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 XX No	Specify:		Specify:	White
ELL 21215-0036	within 72 hours after ene. than "naturel", or Ite	Completed	15. Decedent's Ed (Specify only highest gra	ducation	16a. D	ecedent's Usual Occu Give kind of work done fe. DO NOT use retire	pation	ina	16b. Kind of Busine	ss/Industry
7 2	thin 7	pje.	Elementary/Secondary (0-12)	College (1-4or 5-	+)	fe. DO NOT use retire	ed)	,9		
M 12	od wil	ပ္ပ	6	1000	Hom	emaker	1		Own Home	<u> </u>
8 5	verifi Foth Foth	Be	17. Father's Name (First, Middle, Last,				18. Mother's Nam	e (First, Middle,	Maiden Sumame)	
<u>a</u>	Ment Ment	၉	William Herlth					ine Hall		
2 6	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. I feel the marked other than "naturel", or liems 23a or 28e-f show other traumatic event, the Modical Examiner must be notified at		19a. Informant's Name/Relationship (19b. N	Mailing Address (Stree	t and Number or Run	al Route Numbe	r, City or Town, Stat	e, Zip Code)
2 >	and ealth m 27		Larry G. Dasch	(Son)		81 Tanager				
4	of H fite		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery,	isposition (Name of crematory or other pla	асө)	Date	20c. Location - City	or Town, State
Z .	Pag ment ant: ury		`4 ☐ Donation 5 ☐ Other (Specif		Crestl	awn Cemete		/2004	Marriotts	ville, MD
MARM Baltimore. Maryland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Ital Meone.		21. Signature of Funeral Service Oder	1500		22. Name and Addr Hardest	ess of Facility y Funeral	Home. F	P. A.	
	205 20		77-7.4			12 Ridg	ely Avenue	Annar	olis, MD	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that ceused one cause on gach lin-	the death. Do no e.	()			rest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	. HAR	Tration	Tren	monia	١		Onset and Death
	/Medical		resulting in death)	Due to (or as a	consequence of)	:	2.00.00			
. 1.	Examiner		Sequentially list conditions.	b						<u> </u>
UW	p #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury	Due to (or as a	consequence of)	:				
0.00	ecute ind trans	E E	that initiated events resulting in death) Last	c						
760.	be executed ician and burial-transit		resolung in dealin, Last	Due to (or as a	consequence of)					
876	. 0 % 0	dicai		_ d						
9	eath certificate be execu attending physician and for use as the burial-tra	by Physician/Med	IF FEMALE:	23c. If yes, outcome of	of prognancy					
Bo	ath c	lan/	23b. Was decedent pregnant in the past 12 granths?	1 Live birth	2 🗌 Fetal death	3 Ectopic pregnand	у		23d. Date of Month	delivery Day Year
o	the a	sic	1 ☐ Yes 2 2 No 9 ☐ Unknown	4□Pregnant at: 9□Unknown	time of death	5 Other (specify) _				
۵	that the the ded by detac	F.	Part II. Other significent conditions	contributing to death bu	it not resulting in t	ne underlying cause g	iven in Part I.	23e. Did to	bacco use contribut	e to the cause of death?
Division of Vital Becords. P.O. Box 68	Attending Physicien: The law requires that the death certifical redsh. restor: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the	d b		g	•	,		1 □ Y	es 2 No 3	Probably 4 Unknown
Ö	v requ been shoulk	Completed						24a. Was	an 24h Wars	autopsy findings available
Sec.	ne law has b	mpi						autop	sy prior	to completion of cause of
-	: Th cate pag								2 No 10	/es 2□No
#	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		- 0:	26. Place of Deat			
J	Phys this aldu	5.	1 Yes 2 No 27. Manner of Death	Hospital: 1) Inpatier		atient 3 DOA	4 Nursing Ho		ence 6 Other (5 ow injury occurred	Specify)
5	Jing I	ion	1 Natural 5 ☐ Pending	(Month, Day	Year) Inju	ıry Wo	ork?]Yes 2 □No		o,a., o	
: 5	vitendi death. ctor: A y the fu	ica	3 Suicide 6 Could not b	B One Place of Injur	rv - At home, farm	, street, factory, office	-	28f. Location (S	Street and Number of	Rural Route Number,
<u> </u>	after Olre	Certification:	4 Homicide determined	building, etc	. (Specify)	,,,,,,,,		City or Tow	m, State)	
	Hospital or 24 hours afte Funeral Dir itely filled in		29a. Certifier 12 Certifying Pl	nysician: To the best of	of my knowledge,	death occurred at the t	ime, date and place,	and due to the o	cause(s) and manner	as stated.
	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: Atter this certificate he completely filled in by the funeral director, page	Medical	(Check only 2 Medical Exer	miner: On the basis of and manner sta	examination and/	or investigation, in my	opinion, death occur	red at the time, o	date and place, and	due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. Licen	se number	:	29d. Date signed (M	onth, Day, Year)
	->-0) AGA	Ĭ.	au	D4	-3977		anum 1	9 2004
			30. Name and address of person who	completed cause of de	eath (Item 23a) (T	ype, Print)			, ,,,,,,,,	, 200 [,
	(0		Stoke Cherinin	. 501 Horas	out D	Zwe, Cla	in Browne	- m	1. 21	06%
	Sta	ate	31. Rate filed (Month, Day, Year)	32. Registra	r's Signature	9				
	Regist	rar	JAN T = CAN	To the state of the state of	Sie fait					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Committee Comm				Olato of Mai	y	Certificate of	Death		2004	00611
## METSEL BURGESS BURGESS Sale Sales of Processing Center Sale Sales of Processing Center Sale Sales of Processing Center Sales Sales of Processing Center Sales Sales of Processing Center Sales Sales Sales of Processing Center Sales Sales Sales of Processing Center Sales S			1. Decedent's Name (First, Middle, L.	ast)			2			3. Time of Deeth
SATISTUTY PRINCE AND FOR COUNTY (Parks) SATISTUTY PRINCE AND MUNICIPAL			WHETSEL BUR	GESS						9:15 AM
Function Control Con			4a Facility Name (If not institution, gi	ve street and number)			4b. City, Town, or Loca	tion of Death	4c. County of Death	
Company Comp			Salisbury Rehab a	and Nursing	Center		Salisbury	, Md.	Wicomi	co
Company Comp		Funeral			-	Months Day	r If Under 24 Hrs. 8 s Hours Min.	. Date of Birth (Month, Day,)	Year) 9. Birth	place (State or Foreign
SECURIO S. Silver J. Do. Silver and Number 100 S. Silver J. Do. Silver and Number 100 S. Silver J. Do. Silver and Number 100 S. Silver and Number 100 S. Silver and Number 100 S. Silver and Number 100 S. Silver and Number 100 S. Silver and Number 100 S. Silver and Number 100 S. Silver and Number 100 S. Silver and Number 100 S. Silver and Number 100 S. Silver and Number 100 S. Silver and Number 100 S. Silver and Number 100 S. Silver and Number 100 S. Silver and Number 100 S. Silver and Number 100 S. Silver and Number 100 S. Silver and Sil		Director	404-20-1715	NAM ZUP	77	rs.	J	ULY 13,	1926 KENT	UĆKY
Secretary Secr		pue .		1	Oc. City. Town	or Location				10d Inside City Limits
Secretary Secr		faryle r sho								
Secretary Secr		the A		ONDEL	GUEN D			100	Citizen of What Cou	
Secretary Secr		with D.								
Secretary Secr		leath		12. Was Decedent Ev	er in U.S.					
Secretary Secr		fler of the rest o		Armed Forces?		If Yes, specify Cu	ban, Mexican, Puerto Ric	can, etc.)		
Secretary Secr	07	urs a	3√Widowed 4 □ Divorced	If Yes, Give		1 ☐ Yes 2 🟋 No	Specify:		Specify: WH	ITE
Secretary Secr	Ō	2 ho	15. Decedent's E	ducation	16a.	Decedent's Usual Occi	upation	16	6b. Kind of Business/Ir	ndustry
Physician Middled Examinor The post-group of th	215	thin 7								
Physician Middled Examinor The post-group of th	335 21	gien in the control of the control o	12		WAI	REHOUSE MAN	AGER	1	DEFENSE	
Physician Middled Examinor The post-group of th	nd G	a Hybrid	17. Father's Name (First, Middle, Las)			18. Mother's Name (F	First, Middle, Ma	aiden Surname)	
Physician Middled Examinor The post-group of th	Bul	Ment Ment arked	MOSE BURGESS				NORMA A	MBURGY		
Physician Middled Examinor The post-group of th	Ta F	2 shd end is m	19a. Informant's Name/Relationship	Type, Print)	19b.	Mailing Address (Stree	et and Number or Rural F	Route Number, (City or Town, State, Zi	p Code)
Physician Middled Examinor The post-group of th	SE,	end ealth m 27		SON						
Physician Middled Examinor The post-group of th	E S	or off		Removal from State	20b. Place of cemeter	Disposition (Name of v, cremetory or other pl	ace) JAN	Date 13,	c. Location - City or T	own, State
Physician Middled Examinor The post-group of th	E E	ment tant:	4 Donation 5 Dother (Speci	(y)	CROWNS					MD
Physician Middled Examinor The post-group of th	3a	eperit nport ny in tice.	21. Signature of Funeral Service Lice	nsee		22. Name and Add	ress of Facility	AL HOME	Ρ.Α.	
Physician Medical Examiner Part Enter the disease, or complete ones that caused the deeth. Do not erter the mode of dying, such as cardiac or respiratory arrest, increased the deeth. Do not erter the mode of dying, such as cardiac or respiratory arrest, increased the deeth. Do not erter the mode of dying, such as cardiac or respiratory arrest, increased the deeth. Do not erter the mode of dying, such as cardiac or respiratory arrest, increased the deeth. Do not erter the mode of dying, such as cardiac or respiratory arrest, increased the deeth. Do not erter the mode of dying, such as cardiac or respiratory arrest, increased the deeth. Do not erter the mode of dying, such as cardiac or respiratory arrest, increased the deeth. Do not erter the mode of dying, such as cardiac or respiratory arrest, increased the deeth. Do not erter the mode of dying, such as cardiac or respiratory arrest, increased the deeth. Do not erter the mode of dying, such as cardiac or respiratory arrest, increased the deeth. Do not erter the mode of dying, such as cardiac or respiratory arrest, increased the deeth. Do not erter the mode of dying, such as cardiac or respiratory arrest, increased the deeth. Do not erter the mode of dying, such as cardiac or respiratory arrest, increased the deeth. Do not extend the mode of dying, such as cardiac or respiratory arrest, increased the deeth. Do not extend the mode of dying, such as cardiac or respiratory arrest, increased the deeth. Do not extend the mode of dying, such as cardiac or respiratory arrest, increased the deeth. Do not extend the mode of dying, such as cardiac or respiratory arrest, increased the deeth. Do not extend the mode of dying, such as cardiac or respiratory arrest, increased the deeth. Do not extend the mode of dying, such as cardiac or respiratory arrest, increased the deeth. Do not extend the mode of dying, such as cardiac or respiratory arrest, increased the deeth. Do not extend the mode of dying, such as cardiac or respiratory arrest, increased the deeth. Do not ext		70 E # 9	In I Cha	0						061
Physician Modical Examiner To get a processor of the pro		ST-183	23a. Part1. Enter the disease, or con shock, or heart failure. List only	pions that caused the no cause on each line.	e deeth. Do n	ot enter the mode of dy	ring, such as cardiac or r	espiratory arres	t,	Approximate Interval Between
disease of condition and provided to the control of	4					Comp.				Onset and Death
Due to (or as e consequence of): Due to (or as e consequence of):			disease or condition	a. P.	remis	un			i	4 days
The following of the state of t			resulting in death)	Du	ue to (or as e c	onsequence of):			1	
The following of the state of t		nine		b						
The following of the state of t	•	and and al-tree	Sequentially list conditions, if any, leading to immediate	Du	e to (or es e c	onsequence of):			1	
The following of the state of t	92	siciar buni	Cause (Disease or injury	c					<u> </u>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	687	ficete p physics the edic	resulting in death) Last	Du	e to (or as a c	onsequence of):			1	
State St	×			d						
State St	ă	eath d for	Port II. Other elgoificent conditions	contributing to dooth but s	not soculting in	the underlying seven	ives in Deat I	22h Didasha		a the same of death?
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 31. Date filled (Month, Day, Year) 32. Registrer's Signature 33. Date filled (Month, Day, Year) 34. Date filled (Month, Day, Year) 35. Registrer's Signature	0	the cy the scheen		the same	iot resulting in	the underlying cause g	iven in Part I.			
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 31. Date filled (Month, Day, Year) 32. Registrer's Signature 33. Date filled (Month, Day, Year) 34. Date filled (Month, Day, Year) 35. Registrer's Signature	Œ.	thet ned to a det	Hkheimer s	amenta				1 🗆 103	JE NO S⊟FIG	Dabiy 4 Dilkilowii
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 31. Date filled (Month, Day, Year) 32. Registrer's Signature 33. Date filled (Month, Day, Year) 34. Date filled (Month, Day, Year) 35. Registrer's Signature	Ę,	n sig uld b								ere autopsy findings
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 31. Date filled (Month, Day, Year) 32. Registrer's Signature 33. Date filled (Month, Day, Year) 34. Date filled (Month, Day, Year) 35. Registrer's Signature	ပ္ပ	s bee						penorme	cc	mpletion of cause
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 31. Date filled (Month, Day, Year) 32. Registrer's Signature 33. Date filled (Month, Day, Year) 34. Date filled (Month, Day, Year) 35. Registrer's Signature	æ	he ta						17 Yas	No 11	TYes 2∏No
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 31. Date filled (Month, Day, Year) 32. Registrer's Signature 33. Date filled (Month, Day, Year) 34. Date filled (Month, Day, Year) 35. Registrer's Signature	ta	iffical tor. p					26. Place of Death //			
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 31. Date filled (Month, Day, Year) 32. Registrer's Signature 33. Date filled (Month, Day, Year) 34. Date filled (Month, Day, Year) 35. Registrer's Signature	<u>></u>	ysicia s cer direc		Hospital: 1 ☐ Inpatient	2 ☐ ER/Out	patient 3 DOA	thor:			(v)
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 31. Date filled (Month, Day, Year) 32. Registrer's Signature 33. Date filled (Month, Day, Year) 34. Date filled (Month, Day, Year) 35. Registrer's Signature	Ö	Physical seral		28a. Date of Injury	28b. T	ime of 28c. Inju				,,
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 31. Date filled (Month, Day, Year) 32. Registrer's Signature 33. Date filled (Month, Day, Year) 34. Date filled (Month, Day, Year) 35. Registrer's Signature	<u>ö</u> .	ath. r: Aft ne fur atio	2 ☐ Accident investigation	n						
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Charles B, S () (a, T, M) 1346 S. Division St.Suite, Salisbury, Md.21804 State 31. Date filed (Month, Day, Year) 32. Registrer's Signature	<u>×</u>	Atte er de recto by th	dataminad	e 28e. Place of Injury building, etc. /	- At home, far	m, street, factory, office	28f			al Route Number,
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Charles B, S () (a, T, M) 1346 S. Division St.Suite, Salisbury, Md.21804 State 31. Date filed (Month, Day, Year) 32. Registrer's Signature	Ö	tal or as eft or		Danieling, etc. (
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Charles B, S () (a, T, M) 1346 S. Division St.Suite, Salisbury, Md.21804 State 31. Date filed (Month, Day, Year) 32. Registrer's Signature		lospi t hou uner uner uner icai	29a. Certifier Cortifying Pt	ysician: To the best of m	ny knowledge, amination and	death occurred at the t	ime, date and place, and	I due to the caus	se(s) and manner as s	tated.
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Charles B, S () (a, T, M) 1346 S. Division St.Suite, Salisbury, Md.21804 State 31. Date filed (Month, Day, Year) 32. Registrer's Signature	*	the Find 24 the Find 24 the Find 24 the Find 34 the Fi	one)	and magner stated	d.					
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Charles B, Silvia, Tambo 1346 S. Division St.Suite, Salisbury, Md.21804 State 31. Date filed (Month, Day, Year) 32. Registrer's Signature		Twit To	29b. Signature and title of certifier					29d	Date signed (Month,	∪ay, rear)
State Charles B, S, Va MB 1346 S. Division St. Suite, Salisbury, Md. 21804 32. Registrer's Signature		1	buddle				1012)		1/7/08	
State 31. Date filed (Month, Day, Year) 32. Registrer's Signature		6		200	h (Item 23e) (*	Гуре, Print)				
State					Cianatura	1346 S.	Division St	Suite,	Salisbury,	Md.21804
Registrar 100 1 4 2004 Appear to the second	4	S1398		Ď.	Signature	Legallo 3				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar AMFND TTFM 10g, 18&30 PFR FH C827 1/Certificate of Death

1. Decedent's Name (First, Middle, Last) 2. Date of Death JÄNUARY **Physician** 11, 2004 5:35 A M BERMAN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE COCKEYSVILLE MARYLAND MASONIC HOME If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) SEPT. 9, 1904 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Social Security Number Days **Funeral** 1**⋈**M 2□F Months 216-05-1117 99 MD Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be motified at 1 ☐ Yes 2 ☐ No Director BALTIMORE COCKEYSVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A WHITE 300 INTERNATIONAL CIRCLE #T3A 21030 death by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? be filed within 72 hours after ntal Hygiene. t Never Married 2 Married ☐Yes 2XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛱 No Specify WHITE 3 X Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LIGHTING CONSULTANT HOFFMAN ELECTRIC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Health and Menta em 27 is marked BERMAN FANNIE SAMUEL LESSER Pages 1 and 2 should nent of Health and Men ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7 PICASSO COURT - BALTIMORE, MD 21208 ROBERT GAMSON / NEPHEW 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition permit. Pages 1
Department of H
important: If ite
eny injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State HEBREW FRIENDSHIP CEM. 1/12/2004 BALTIMORE, MD A ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** lerotre Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetel death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 Yes 2 No 3 Probably 4 ₩nknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page 2 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 2 No 1 Inpatient Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ို 1 Tes 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: or Attending 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours after deatl To the Funerel Director: 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) in by 4 - Homicide filled 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely the e 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 D20649 2004 CP address of person who completed cause of death (Item 23a) (Type, Print) h JOHN W. BOWTE
31. Date filed (Month, Day, Year)
JAN 1 4 2004 MARYLAND MASONIC HOME COCKEYSVILLE,MD 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of Maryland		nt of Hea		307	ene 200	4 0061
	Physici /Medi Examir	cal	1. Decedent's Name (First, Middle, Last) ROBER 4a. Fecility Name (If not institution, give s 925 NORTH	T LEE treet and number) ROSEDALE S		OMAR y, Town, or Loc BAL		2. Date of Death Month	Day Year / 200 4c. County of De	04 6.40 FM
	Funeral Director		5. Social Security Number 6. Sex 12/4-70-755 8 12 Usual Residence of Decedent	M 2□F	st birthday) If Und Month		Under 24 Hrs. ours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. B	irthplace (State or Foreign Country) IARYLANL
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itama 23a or 28a-f show any injury or other traumatic event, the Madical Examination in publical examination on 200.	To Be Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12) 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Typ MONTRESSA ROM 20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenser	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ZNo If Yes, Give Year or Dates: ation College (1-4or 5+) CRO ARTIE (WIFE) IMARTIE (13. Was Decilif Yes, signification of the Internation ual Occupation or done during use retired) 18. (Street and North of the place) CEME and Address of SEV H	most of working most of working most of working most of working most of working most of most o	AVE., X	ity or Town, State, BALTO, c. Location - City o	SA. nerican Indian, ite, etc. LACK s/Industry RIAL SERVICO Zip Code) MD 2/2 16	
8760,	Physician /Medical Examiner the private fransit	ical Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death) 5. Juantally list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last d.	Due to (or as a consequent	nce of):	inde of dying, su	<u> </u>	r respiratory årrest,		Approximate Interval Between Onset and Death I monto
.O. Box 68	ath certific	Physiclan/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregnanc 1 Live birth 2 Fetal di 4 Pregnant at time of deal	eath 3 Ectopic				23d. Date of de Month	livery Day Year
Records, P.	w requires that the de been signed by the a should be detached f	Completed by Ph	Part II. Other significant conditions cont	ributing to death but not resulti	ing in the underlying	cause given in	Part I.	23e. Did tobace	2 □ No 3 □ P	o the cause of death? robably 4 Unknown utopsy findings available
	Physician: The lav r this certificate has ral director, page 2 is	Be Comp	25. Was case referred to medical examiner?			26.	Place of Death	autopsy performed 1 Yes 2 (Check only one)	prior to death?	completion of cause of
Division of Vital	ftel in e	Certification; To	1 Yes 2 No Ho 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	spital: 1 Inpatient 2 EF 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At hombuilding, etc. (Specify)	Bb. Time of Injury M	28c. Injury at Work? 1 ☐ Yes	2 🗆 No	8d. Describe how in	and Number or R	ural Route Number.
_	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical	one)	cian: To the best of my knowle er: On the basis of examination and manner stated.	edge, death occurre n and/or investigatio	d at the time, da	ite and place, a , death occurre	nd due to the cause d at the time, date	e(s) and manner as and place, and due	s stated. to the cause(s)
	To the within 2 To the complete	₹.	29b. Signature and title of certifier 30. Name and address of person who com	Physic pleted cause of death (Item 23	_	00060			Date signed (Mont	n, Day, Year) 14, 2004
	Sta Registr		Anna Hemnes 31. Date filed (Month, Day, Year)	9021 1830 32. Registrar's Signature	EastN	mum	ent st	reet. E	Baltim	ove

ORIGINAL

			1 - For State Registrar	State of Ma	ryland /	-	artment rtificate			and M	_	giene Reg. No	7 11 11	00611
-	Physici /Medic	al	Decedent's Name (First, Middle, Last) Aa. Facility Name (If not institution, give s	Day street and number)	id	L	4b. City. 1	Cown, or	O O	of Death	2. Date of De Month	Da 12		3. Time of Death 3. Oo A M
	Examin Funeral Director		Howard County Ge 5. Social Security Number 6. Sex	eneral Hos	(In yrs. last b	irthday) Yrs.	,	olum)		24 Hrs. Min.	8. Date of Bir (Month, Da Oct. 18	th	Howard 9. Birth	
	שַ		Usual Residence of Decedent 10a. State 10b. County Maryland Howard 10e. Street and Number	a	10c. City, To	wn or Lo								10d. Inside City Limits 1 ☐ Yes 2∑ No
980	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 ie marked other than "naturel", or items 23e or 28e-f show other treumetic event, The Wedical Evandrant must be multified at	by Funeral Director	11. Marital Status 1□ Never Married 2☆ Married 3□ Widowed 4□ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			Was Deced f Yes, spec			gin? (Spe i, Puerto F	cify Yes or No Rican, etc.)		14. Race - Ameri Black, White, Specify: Wh	can Indian,
21215-0036	id within 72 hor giene, er then "nature, the Medical E	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 11			(Give life.	dent's Usua kind of worn DO NOT us UCK DI	k done di e retired)	uring most	t of workir	g		(ind of Business/Ir owan Tru	
Maryland	2 should be filed withir and Mental Hygiene, ie marked other than eumetic avent, Ins M	To Be (17. Father's Name (First, Middle, Last) Carl Ramstad 19a. Informant's Name/Relationship (Ty,	oe, Print)			_	(Street a	Vivi nd Numbe	an M		er, City	or Town, State, Zij	
Baltimore, Ma	Pages 1 and 2 nent of Health a int: if item 27 ie iry or other tre		Carol Cook - Wife 20a. Method of Disposition 1 Burial 2 Scremation 3 B 4 Donation 5 Other (Specify)	emoval from State	20b. Place cemet	of Dispo	-	e of her place)	D	Elkrido ate 6/04	20c. L	Maryland ocation-City or T rel, Mar	own, State
Baltir	permit. Pages Department of Important: if it eny injury or o		21. Signature of Funaral Service License 23a. Part 1. Enter the disease, or compli			G 7	Name and ary L. 250 Wa	Address Kat ashir	of Facility Ifman Igton	Fun Blv		ome krid		Inc. 1and 21075
8760,	iste be executed whysician and whysician and whysician and the bunat-transit	ilcal Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate any. Each of the cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Due to (or a) Due to (or as a Due to (or a) Due to (or a	conséquence	e of):	ax				1 06			Approximate Interval Between Onset and Death 2 Months
P.O. Box 68	Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal dea		Ectopic pre						23d. Date of deliv Month	ery Day Year
Records, P	aw requires that is been signed b 2 should be deta	Completed by Pf	Part II. Other significant conditions cor	atributing to death but	t not resulting	in the u	nderlying ca	use give	n in Part I.		1 _	Yes 2 an	No 3 ☐ Pro	he cause of death? bably 4 Minknown ppsy findings available impletion of cause of
Vital	ding Phyeicien: The lav n. After this certificate has funeral director, page 2:	To Be Com	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	lospital: 1 XInpatien	t 2□ER/0	Outnatier	nt 3□ DO	∆ Othe	r		perfo 1 ☐ Yes (Check only o	ormed? 2 X No one)	death?	2 No
Division of	Jing Afte fune	Certification: T	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined	28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc.	Year) 28b	Time o	f 28	Sc. Injury Work 1 🗆 Y		No 2	8d. Describe l	how inju Street ar	ny occurred	
	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical Ce		sician: To the best of ner: On the basis of and manner stat	examination a									
	with Com	N	29b. Signature and title of certifier 30. Name and address of person who co	Li Chro	M A	(Tvpe.). [D4	number	32	3	29d. Da	ate signed (Month,	Day, Year) 2004
	Sta Registi		10 8 2 0 H 31. Date filed (Month, Day, Year)	ickory 2. Registral	Ride		Roc	di	CC	elui	nbia		MDZ	1044

			For State Registrar	State of Maryland	d / Department of H Certificate of		ental Hygien Reg. N	71111	00615
	Physicia	an	1. Decedent's Name (First, Middle, Las	Leader Part	maidet		2. Date of Death Month Di JANUARY	ay Year	3. Time of Death
	/Medic	al .	4a. Facility Name (If not institution, give	street and number)		r Location of Death	4	11, 200 c. County of Deet	h
				Medical Cen		TOWS	8. Date of Birth		timore
	Funeral Director			ZM 2□F	Yrs. Months Days	Hours Min.	(Month, Day, Year	22 /N	dava
	ow et		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Location		J		10d. Inside City Limits
1	Ba-1 sh	ctor	7 710	ORe Til	nonium				1 ☐ Yes 2 MNo
	3 or 2	Funeral Director	10e. Street and Number	ward Ct	10f. Zip Code	93	10g. C	itizen of What Co	untry?
ij	tems 2	uner	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. Was Decedent of H II Yes, specify Cub.	lispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
020	ges 1 and 2 should be filed within 72 hours after deeth with the Maryland it of Health and Mental Hygiene. At them 21s is marked other then "natural", or items 23e or 28e-1 show or other traumatic avant, its Medical Francisc must be notified at	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☑Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No	Specify:		Specify: W	rite
<u> </u>	n 72 ho "natur	Completed	15. Decedent's Ed (Specify only highest grad	de completed)	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of workir	na l	Kind of Business/I	
717	filed within Hygiene. Ither then " Int, Ibe Me	Somp	Elementary/Secondary (0-12)	College (1-4or 5+)	MINISTER				church
	ontal Hy	Be	17. Father's Name (First, Middle, Last)	etuspialit		18. Mother's Name	(First, Middle, Maide	n Sumame)	
	2 should and Mer is marke sumatic	으	19a, Informant's Name/Relationship (7	1 11 0 1	19b. Mailing Address (Street	and Number or Rura	Route Number, City	or Town, State, Z	Tip Code)
c,	1 and Health em 27		20a. Method of Disposition	Right - Wife 120b. PI	ace of Disposition (Name of	enwood	ete_ 20c.	MONIUM Location - City or	MI) 21095 Town, State
attımor	Peges nent of ant: If it ary or o		1 Bunal 2 Cremation 3 U 4 Donation 5 Other (Specify	Removal from State	metery, crematory or other pla SFUKURALL NADA —	Bel Jan	04 FOR	est Hill	MD
Dail	permit. Peg Department Important: I any injury o		21. Signature of Funeral Service Licen	spo de	22. Name and Addre	ss of Facility EVC	Balling Puner	Pal Chap	el 21234
В	· **		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the death	. Do not enter the mode of dyir	no.)such as cardiac o	r respiratory arrest,	X MID C	Approximate Interval Between
ı	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. LEFT VENT	RICULAR RUPT	URE			Onset and Death
	Examiner			Due to (or as a consequence ATHEROSCL	ience of): EROTIC CORON	IARY ARTE	ERY DISEA	ASE	
-	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence ol):				
Ď.	execut en and rial-trar	Exan	that initiated events resulting in death) Last	C. Due to (or as a consequ	ence ol):				
09/80	certificate be executed rding physicien and ise as the burial-transit	dlcal	•	d					
POX P	ding ding	an/Me	IF FEMALE: 23b. Was decedent pregnant	23c. II yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		,		23d. Date of deli	,
	he death the atter ched for u	Physiclan/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time of de 9□Unknown				Month	Day Year
λ, J	requires that the reen signed by th hould be detache	by Ph	Part II. Other significant conditions of	ontributing to death but not resu	ilting in the underlying cause give	ren in Part I.			the cause of death?
ecords	ned ned						1 ☐ Yes 24a. Was an		
T	e la has	Completed					autopsy performed?	prior to death?	topsy findings available completion of cause of
	ysician: Th	Be C	25. Was case referred to medical examiner?			26. Place of Death			
> 0	S D	မှ	1 ☐ Yes 2 🗶 No		ER/Outpatient 3 DOA Ott	Turing Tro	ne 5 Residence		cify)
	Jing After	atlon	27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	Injury Wo	yat rk? Yes 2 □ No	28d. Describe how inj	ury occurred	
DIVISION	or Attandi fter death. Director: A in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, larm, street, factory, office	-	281. Location (Street a City or Town, Sta		ral Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral			ysician: To the best of my knowniner: On the basis of examinat					
	thin 24 the Fu	Medical	(Check only 2 Medical Examone) 29b. Signature and title of certifier	and manner stated.	29c. Licens			ate signed (Month	
1	¥ ¥ €		> /lens	- ins		8655		NUARY 12	
	V		30. Name and address of person who	completed cause of death (Item	23a) (Type, Print)				
	Sta	ite	STEWART FINNE) 31. Date filed (Month, Day, Year)	4 2004. Registers Signa	tyre D. A. R. L.		L MARYLAN	ID 21204	4

				State of Maryland / Department of Health and i	Mental Hygie	ne ₂ no l	00010
2				1 - State Certificate of Death	Reg	. No. 2 U U 4	00016
		Physici	30	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death
		/Medic		Upal t. Lorbin	JAN	9 2004	6.511.M
		Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	n	4c. County of Death	1
		Eurovol		5. Social/Security Number 6. Setx 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yo	9. Birth	nplace (State or Foreign
		Funeral Director		224-510-0086 1 M 20 F (0) Yrs. Months Days Hours Min.	(Month, Day, Yo	-42. V	ROSPIO
	2			Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	laryla	s hov	5				1 Yes 2 No
	death with the Maryland	28a-f	Director	10e. Street and Number 10f. Zip Code	100	. Citizen of What Cor	
	¥	io e	ᅙ	3137 Augen Castle Road 21084		1151	7
	deatt	E E	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (S	Specify Yes or No-	14. Race - Amer Black, White	
	after a	함	Ē	1 Never Married 2 Married 1 Yes 2 No 1 Yes 20 No Specify	o nican, etc.)	Specify: //	6:11
	1215-0036 within 72 hours after	LEXA	d by	3 □ Widowed 4 □ Divorced Year or Dates:		W	1)146.
	15-	adlo	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired)	rking	b. Kind of Business/l	ndustry
	712 Affil	then then	E	Elementary/Secondary (0-12) College (1-4or 5+)	j.	tospito	\mathcal{O} .
	1d 2	other	BeC	17. Father's Name (First, Middle, Last) 18. Mother's Name	me (First, Middle, Mai	iden Sumame)	
85	rlan,	Mental arked c	10 B	James Taylor un	K.		
00	Maryland 21215-0036	and E E		19a. Informant's Name/Relationship (Trans, Print) 19b. Mailing Address (Street and Number or Ru	ural Route Number, C	ity or Town, State, Z	ip Code)
		Health tem 27 other tre		Linda Sedler-daughter 4043 Giltord Ct.	JARRETT.	SVILLE	MD 21089
4	altimore,	P = P		20a. Method of Disposition 20b. Place of Disposition 7Name of commettery, crematory or other place)	Date 200	c. Location - City or 1	lown, State
9(04	i ii	Department of Importent: If It any injury or o		· 4 Donation 5 Other (Specify) Bollic Menorical Cardens 1-	12-04 8	sol Hir,	MD
0	Balti	Deparement		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 3	का ०व धाउँ।		RESTHILL,
				23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	or respiratory arrest.	AIR, MI	Approximate
_				23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one gause on each line. Immediate Cause (Final disease or condition			Interval Between Onset and Death
		nysician Medical	П	disease or condition resulting in death) Due to (or as a consequence of):			5 DAYS
	E	xaminer		METARTATIC REPAST CA	NGER		2/2 40AME
			ē	Sequentially list conditions, If any, leading to immediate Cause Enter Underlying			
	cutec	nd transi	Examin	that initiated events			
	50,	physiclan and the burlat-transit	Ä	Due to (or as a consequence of):			
	8760,	physic The b	dical	d			
GL8081	6	attending p	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deliv	varv
00	P.O. Box	atten I for u	Cian	in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy		Month	Day Year
200	0 8	ed by the detached	Š	1 Yes 2 Tho 9 Unknown 9 Unknown			
7	S that	signed t d be det	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
2		been sig	B	SEIZURE DISCROEL	1 ☐ Yes	25 No 3 □ Pro	bably 4 Dunknown
	ecc awa	as be 2 shi	Pe e	COAGULASE NEGATIVE STAPHLOCOCCOS BYCHE	14a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
	E E		Completed	PEHYDIZATION	performed 1 □ Yes 25	death?	2500
pal Corbin	Division of Vital Records,	s certificate has t lirector, page 2 s	Be	examiner?	ath (Check only one)		
0	Of Physi	this gal dir	오	To the state of th	lome 5 Residence		ify)
0	C D	h. After this funeral di	章	1 Natural 5 Pending (Month, Day Year) Injury Work?	253. 503050 11011	inary occurred	
a	Vision	after death. Director: A In by the fu	Certification;	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office		t and Number or Rui	ral Route Number,
8	D S	after I Dire	ert.	4 Homicide building, etc. (Specify)	City or Town, S	tate)	
	Di Di	within 24 hours after death. To the Funeral Director: After this certific completaly filled in by the funeral director,		29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place Check only Check on			
	10 th	within 24 To the F complete	Medical	one) and manner stated.			
, 4	é	To	2	29b. Signature and title of certifier 29c. License number		Date signed (Month	
		3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	CLASTORSA	NO ARY 9	/
				I III CA DILLIAN TO	MD 21	014	
		Sta	te	31. Date filed (Month, Day, Year) 32 Registrar's Signature		<u> </u>	
		Registr		JAN 1 2 CUP! JORGAN JO 19			

		-	For State of Maryla		artment of Health a tificate of Death		jiene _{eg. No.} 2004	00617
	Physicia		1. Decedent's Name (First, Middle, Last)		EMAN	2. Date of Dea Month JANUAR	th Day 2004	3. Time of Death 3:00 A M
	/Medic Examin	er	49. Fecility Name (If not institution, give street and nymber) JOSEPH RITCHIE HOSPIC	E	4b. City. Town, or Location of BATI mo	LE	4c. County of Deal	
	Funeral Director		439.30.3638 10M 200F 8	rrs. last birthday) Yrs.	If Under 1 Year If Under Months Days Hours	Min. 8. Date of Birth Month, Day	9. Bin 0, 1916 Lou	tholece (State or Foreign buntry)
	Aaryland f ehow	ō	Usual Residence of Decedent 10a. State 10b. County 10c. KAT7	City, Town or Lo				10d. Inside City Limits 1 LYes 2 □ No
	r death with the Maryland tame 23e or 28e-f ehow er must be notified at	Direct	10e. Street and Number 729 E. COUDSPRING LANE		10f. Zip Code 217		10g. Citizen of What Co	ountry?
920	or the	by Funeral Director	11. Maritat Status 1	n U.S. 13. \	Was Decedent of Hispanic Ori f Yes, specify Caban, Mexican 1 Yes 2 No Specify:	gin? (Specify Yes or No- n, Puerto Rican, etc.)	14. Race - Ame Black, Whit Specify:	
21215-0036	within 8ne. then	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usual Occupation kind of work done during mos DO NOT use retired) NURSES A	t of working DE	16b. Kind of Business.	
Maryland	ed la b	To Be C	17. Father's Name (First, Middle, Last) JOHN GIVENS		18. Mothe	er's Name (First, Middle, MIULE	1	
	nd 2 s lith ar 27 io r trau		19a. Informant's Nama/Relationship (Type, Print) DOROTHY D. SMITH / FRIEND	8529	ng Address (Street and Number	ANE KAN)AUSTOWN	MD 21244
altimore,	Pages nent of ant: if if ury or o		20a. Met/Mod of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		natory or other place)	1.14.04	20c. Location - City or	
Balt	permit. Pag Department Important: eny injury o		21. Signature of Funeral Service Licensee UMM Licensee Licensee	22	2. Name and Address of Facility POS YORK RI	w vaught c.	ure, wo	Approximate
8760,	Physician and white price of th	dical Examiner	23a. Part1. Enter the disease, or complications that caused the disease or condition. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a condition or condition or condition or condition or condition or condition or cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a condition or condition or condition or condition or condition or condition or cause or condition or cause on each line.	isequence of):	of Bresn	WITH	Mest3	Interval Between Onset and Death
Box 6	ne death certific the attending p hed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ Femant at time 9 ☐ Unknown 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of de Month	olivery Day Year
ds, P.O.	w requires that the described signed by the should be detached	by	Part II. Other significant conditions contributing to death but not	resulting in the u	inderlying cause given in Part		obacco use contribute to	
Recor	The law requate has been page 2 should	Completed				24a. Was autop perfor 1 Yes	sy prior to death?	utopsy findings available completion of cause of
Division of Vital Records,	the Hospital or Attending Physician: The law requires that the death certific in 24 hours after death. The Funeral Director: After this certificate has been signed by the attending pepietely filled in by the funeral director, page 2 should be detached for use as:	Certification: To Be	27. Manufer of Death 1 Natural 5 Pending (Month, Day Year investigation) 2 Accident investigation		nt 3 DOA Other: 4 N of 28c. Injury at Work? M 1 Yes 2	No		popula
Div	i Sign		4 Homicide determined building, etc. (Sp	oecify)		City or Tow	m, State)	
	To the Hospital or Attent within 24 hours after death to the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my (Check only one) 1 Medical Examiner: On the basis of examiner: On the basis of examiner and manner stated.	mination and/or in	in occurred at the time, date as a second of the second of	ath occurred at the time, o	cause(s) and manner a date and place, and du 29d. Date signed (Mon	e to the cause(s)
			· I MU WI MIMME!	(Item 23a) (Tybe,	P 130/	2	1/8/0	94
		ate	30. Na and address of parent who impleted Puse of death 31. Date filed (Month, Day, Year) 32. Registrar's S	11 MM	HENDOON?	a Ball	MA 2	212/8
	Regist	rar	JAN I 4 2004 Siener	no la	Soor de			

DHMH 17 Rev 1/2001

Marquerite Coleman 1/8/04

			1 - For State Registrar	State of Marylan	d / Depa	artmen rtificat	t of He	eaith a Death	ind Me		giene Reg. No.	200	. 00	618
	Physici	an.	1. Decedent's Name (First, Middle, La.	st)					2	Date of Dea Month	ath Day	/ Yeer	3. Time	of Death
	/Medic			ray Carter, Sr	•					anuary			9:55	AM
	Examir	er	4a. Facility Name (If not institution, give			4b. City,		Location o	f Death		4c.	County of Dea		
- 100	Funeval	\$15 p	Gilchrist Cer 5. Social Security Number 6. S		last birthday)	If Under	Tows	SON If Under 2	24 Hrs. 8	Date of Birtl	h	Balti 9. Bi	rthplace (State	or Foreign
	Funeral Director			™ 2□F 76	Yrs.	Months	Days	Hours	Min.	(Month, Da) une 17	, Year)	0	irginia	
	/land		10a. State 10b. County	10c. City	y, Town or Lo	ocation							10d. Inside (City Limits
	the Marylan 28s-f ehow	tor	Md. Bali	timore		Luth	ervi [.]	lle					1 ☐ Ye	s 2 XX No
	th the)irec	10e. Street and Number	1		10f. Zip					10g. Citi	zen of What C	ountry?	
	ath w	rai	1542 Pickett Ro				210					USA		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene importent: If item 27 ie marked other than "netural", or items 23e or 28e-f ehow apply injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates: WW ☐	_	Was Deced If Yes, spec 1 ☐ Yes			gin? (Specii , Puerto Ric	y Yes or No- an, etc.)		14. Race - Am Black, Wh Specify:		
9	2 hou	ted	15. Decedent's Ed	ducation	16a. Dece	dent's Usua	al Occupa	tion			16b. Ki	nd of Busines:		
21215-0036	hin 7.	pie	(Specify only highest gra	de completed) College (1-4or 5+)	(Give	kind of wo DO NOT us	rk done di se retired)	uring most	of working					
	filed wit Hygiene other the	Completed		4		Inv		gator				d & Dru	g Admir	n
pu	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)					18. Mother	r's Name (F	irst, Middle,	Maiden	Sumame)		
Maryland	should be fund Mental he marked of	ည	William L. Ca							. LeBa				
Mar	12 sh h and 7 le n fraun		19a. Informant's Name/Relationship (177.3	r Town, State,	2000	
	1 and Health Iem 27 other to		Mrs. Dorothea Cal 20a. Method of Disposition	20b. P	lace of Dispo	sition (Nan	ne of		Luthe	rville		eryland		
nor	Pages nent of I int: If it		1 🖾 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Hemoval from State	emetery, crei	•			1 /1	E / O /	Time		Mararilar	a d
Baltimore,	nit. Partme orten injur		21. Signature of Funeral Service Licer		aney v	diley 2. Name an	d Address	of Facility	· I/I	70WS0	n Fi	onium, uneral	Mary I a	Inc
B	permi Depa Impo eny ir		mel	1 rust		1050	York	c Roa	d To	wson.	Mary	land 2		IIIC.
	Physician		23a. Part 1. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final	,)	ente		e of dying	, such as	cardiac or r	espiratory an	rest,		Approxima Interval Be Onset and	etween
	/Medical		disease or condition resulting in death)	a. Due to (or as a consequence		77							gra	LS
	Examiner		Cognoptially list conditions	b										
	ν =	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a consequ	uence of):									
	ificate be executed g physicien and as the burial-transit	cam	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequ			<u>_</u>							
8760,	cien a	E	1000	Due to for as a consequ	uerice or):									
	physi physi the b	edicai		d										
Box 6	eath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna								23d. Date of de	livery	
B	death a atter d for u	Physician/M	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		⊒Ectopic pr ⊒ Other <i>(sp</i>						Month	Day	Year
0	t the c by the achec	hysi	9 Unknown	9 Unknown					_					
Records, P.	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	۵	Part II. Other significant conditions of	contributing to death but not resi	ulting in the u	nderlying c	ause givei	n in Part I.		23e. Did to		se contribute t		death?]Unknown
Sor	w requir been si should	lete								24a. Was a	an .	24h Were a	utopsy findings	s available
Re	he lav e has	Completed								autop	sy med?	prior to death?	completion of	cause of
Vital	ding Physician: The n. After this certificate hi funeral director, page	Be Co	25. Was case referred to medical					26 Place	of Death ((1 ☐ Yes Check only or	28 No	1 □ Ye	s 2□No	
Ş	Physician: this certificaral director, I	To B	examiner? 1 □ Yes 2 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3 DC	Othe	-		5 ☐ Resid		Other (Spe	ecity) Hosy	oice
J Of	ding Phy.		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	f 2	8c. Injury Work			1. Describe h		y occurred	/	
joi	Attending r death. actor: After by the fune	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	n	,,	М		es 2 🗆 N	10					
Division	el or Atto s after de il Directo id in by th	Certification:	3 Suicide 6 Could not b 4 Homicide determined		ome, farm, st	eet, factory	, office		281	Location (S City or Tow		d Number or F	ural Route Nui	mber,
7	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical (29a. Certifier 12 Certifying Ph (Check only one) 2 Medical Exer	nysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred vestigation	at the time , in my opi	e, date and inion, deat	d place, and h occurred	I due to the c at the time, c	ause(s) date and	and manner a place, and du	s stated. e to the cause((s)
,	To the To the To the Comple	Me	29b. Signature and title of certifier	1		290	. License	number		2	29d. Date	e signed (Mon	th, Day, Year)	
	211		M Brother	Miley us		()-25	200			Jan	WAY	12,20	204
1	14,		30. Name and address of person who	completed suse of death (Item	1 23a) (Type,	Print)	er St	Pal	7. M.	1212	201	1 UA-Y		
	Sta	ate	31. Date filed (Month, Pay Year)	Registrar's Signa										
	Regist	rar	ONI4 4 = 201	The cours of	601	Sell !								

1-12-04

CAPTER LANDENCE

			For State	State	of Maryla				Mental Hygi	ene ₂ nn	1, 00510
			Registrar			Cei	rtificate of l	<i>Death</i>		g. No.	4 00013
п	Physici	an	1. Decedent's Name (First, Middle Elizabeth			0-			2. Date of Death Month	Day Ye	
	/Medic	al	4a. Fecility Name (If not institution		nda umberl	<u> </u>	4b. City, Town, or	Location of Dea	January	7 2004 4c. County of D	1005 M
	Examin	er	Anne Arundel				Annapo				Arundel
	Funeral		5. Social Security Number	6. Sex		s. last birthday)	If Under 1 Year	If Under 24 Hr			Birthplace (State or Foreign Country)
Ľ	Director		458-34-5452	1 □ M 2/□XF	81	Yrs.	Months Days	Hours Min	Dec. 17	, 1922	Texas
	pu ,		Usual Residence of Decedent 10a. State 10b. County		100.0	City, Town or La	antina .				1011-11011
	aho	ū		A 1 1	700. 0						10d. Inside City Limits 1 Tyes 2 TyNo
	28a-1	Director	MD Anne A	Arundel		Deale	10f. Zip Code		10	g. Citizen of What	
	with Se or	iOi	975 Bay Drive					751	10	USA	Country
	ma 2:	era	11. Marital Status		cedent Ever in	U.S. 13.1			Specify Yes or No- rto Rican, etc.)		merican Indian,
9	or Ite	Fur	1 Never Married 2 Marr	ied 1 X Yes	orces? 2 □ No live 105	1			rto Rican, etc.)		/hite, etc.
03	ral', c	d by	3 ☐ Widowed 4 🏋 Divorced	Year or	Dates: 195	4-56	1□Yes 2∏XNo	Specify:		Specify:	White
21215-0036	72 h "natu	Completed by Funeral	15. Deceden (Specify only highes		n	(Give	ient's Usual Occupa kind of work done	during most of we	orking 1	6b. Kind of Busine	ss/Industry
12	within the m	mp	Elementary/Secondary (0-12)	College 5+	(1-4or 5+)	Physi	DO NOT use retired)		Medical	
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or flema 23e or 28e-f ahow ther, the Medical Examinar must be rotilised at	CO	17. Father's Name (First, Middle,			Tilysi	Clan	18. Mother's Na	me (First, Middle, M		
an	ld be ental ked o	To Be	David Hardee	,					Gazelle P		
Maryland	shound Mind Mind Mind	-	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address (Street a	<u> </u>	ural Route Number,		e, Zip Code)
	aith a 27 is		Mary E. Furlow	(Person	al Rep.	1			MD 2075		
Z.	of He		20a. Method of Disposition		20b.	Place of Dispo	sition (Name of natory or other place			Oc. Location - City	or Town, Slate
Ĕ	Page nent ant: H		1 ☐ Burial 2 ☑ Cremation '4 ☐ Donation 5 ☐ Other (S			-	ematory		3/2004 _B	altimore	, MD
Baltimore,	permil. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23e or 28e-f ahow any injury or other traumatic evant, the Medical Examinat must be notified at once.		21. Signature of Funeral Service	Licensee		22	Name and Addres	s of Facility Funeral	Home, P.		
	205 a a		1.0				12 Ridge	Ly Avenu	e, Annapo	lis, MD	
П			23a. Pert1. Enter the disease, or shock, or heart failure. List	complications that	each line.						Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_a.La	rge 0	inter	100 one	pocarc	dial cry	arction	n 2hr
1	Examiner			Due to	o (duas a conse	equence of):	0		٤		
	lege	e	E aquentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	o (or as a conse	quence of):					
	outed d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	S							
oʻ	cate be executed physicien and the burial-transit	Ex	resulting in death) Last	Due to	o (or as a conse	quence of):					
8760,	ate be hysici the bu	dical		d							
9	entific ling pl	0)	IF FEMALE:	1						10	
Вох	ath cattend	lan/	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregr birth 2 Per	al death 3	Ectopic pregnancy			23d. Date of Month	delivery Day Year
P.O.	The law requires that the death certificate has been signed by the attending or agge 2 should be detached for use as	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unk	nant at time of	death 5∟	Other (specify)				•
م	that ted by deta	V Ph	Part II. Other significant condition	ons contributing to	death but not re	sulting in the ur	nderlying cause give	n in Part I.	23e. Did toba	cco use contribute	e to the cause of death?
rds	w requires t been signe should be	d by	Atrial	ibvilla	ation				1 ☐ Yes	2.00 No 3□	Probably 4 Unknown
00	s bee	Completed	Į.						24a. Was an	24b. Were	autopsy findings available to completion of cause of
Re	The law te has age 2 s	Elo							autopsy performs	prior death	?
ta	rician: Th certificate rector, pag	BeC	25. Was case referred to medical					26. Place of De	ath (Check only one)	200	65 2 140
<u>_</u>	Physician: rthis certificatal director, I	10	examiner?	Hospital: 1	Inpatient 2	R/Outpatien	t 3□ DOA Othe	or: 4 ☐ Nursing I	Home 5 Residen	ce 6 Other (S	pecify)
D U	Ing P		27. Manner of Death 1 ☑Natural 5 ☐ Pendin	g 28a. Date (Mo	of Injury nth, Day Year)	28b. Time of Injury	Work	at ?	28d. Describe how	injury occurred	
Sio	tend leath tor: / the f	cati	2 Accident investig	not be				/es 2 □ No			
Division of Vital Records,	or Al	Certification:	4 ☐ Homicide determ	ined 289. Plac	ding, etc. (Spec	nome, tarm, sire	eet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
_	spital ours ours neral filled		29a. Certifier Cortifyin	o Physician: To th	ne best of my kr	nowledge death	occurred at the tim	e date and niac	e, and due to the cau	co(c) and manner	as stated
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	(Check only 2 Medical one)	Examiner: On the	basis of examin	ation and/or inv	estigation, in my op	inion, death occ	urred at the time, date	and place, and o	lue to the cause(s)
	To th To th comp	Me	29b. Signature and title of certified	0	161		29c. License	number	290	I. Date signed (Mo	onth, Day, Year)
			1 Clourer	- Prei	the	MD	DO	58	480	1/7/0	4
	10		30. Name and address of person			m 23a) (Type,	Print)	n	trucapol	- LIN	0:11=1
	10		0 -05	decal	Merku		Suitest	\sim r	rereapor	IS MID	21401.
	Sta		31. Date filed (Month, Day, Year)	1 /	Registrar's Sign	ature &	A9 .				
54	Registr	z)	JAN 14	2004 1000	Sept for		OEL.				

				State of Marylan				-		_		
			1 - State Registrar	State of Marylan		Certificate of		iu Meritai i	Reg. N	71111	4 (00620
			Decedent's Name (First, Middle, Last)					2. Date of	Death			. Time of Death
	Physici /Medic		SIDNEY N.	CH	ERNA	.K		Month	IARY I	y Yes		3:30 PM
	Examin		4a. Facility Name (If not institution, give str	eet and number)	P.S.	4b. City, Town,	Lá	Death		CRUPTA Of D	ath	
			sinal Hospita	of bal	116	0.0	If Under 24		5	<u>, </u>		
	Funeral Director		5. Social Security Number 6. Sex 17-14-9738	\\ 7. Age (In yrs. \\ 1 2 □ F	0 F	Months Days		Hrs. 8. Date of Min. JAWOnth,	22, Year	908 M	Pruntry)	(State or Foreign
			Usual Residence of Decedent									
	anylan show	_	10a. State 10b. County N/A		y, Town TIMC	or Location						Inside City Limits Y Yes 2 No
	Ne Me	ecto	10e. Street and Number	DAL	11110	· · · · · · · · · · · · · · · · · · ·			10= 0	inima and harban		
	within 72 hours after death with the Maryland ene. Than "netural", or Itams 23a or 28a-f show he Medical Evariliral must be notified at	Funeral Director	7121 PARK HEIGHTS A'	VE #808		10f. Zip Code 21215			USA	itizen of What	Country	
	death	nera	11. Marital Status 12	Was Decedent Ever in U. Armed Forces?	S.	13. Was Decedent of I If Yes, specify Cub	Hispanic Origin	? (Specify Yes or	No-	14. Race - A		ndian,
92	or Its	y Fu	1 Never Married 2 Married	1 ⊟Yes 2 □XNo If Yes, Give		1 ☐ Yes 2 X☐ No		dento rincari, etc.,		Black, W Specify:WH		
ĕ	hours tural',	d b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educa	Year or Dates:	160	Panadant'a Hayal Ossu	-ation		105	Kind of Busine		
5	in 72 n "ne n "edic	piet	(Specify only highest grade of	ompleted)	Toa.	Give kind of work done life. DO NOT use retire	during most of ed)	f working	BAL	ΓIMORE	CITY	PUBLIC
212	d with giene or tha	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 5 +		SISTANT SUP			SCHO	OOL SYS	TEM	
g	be file ta! Hy d othe	Be	17. Father's Name (First, Middle, Last) ISAAC	CHERN	ΔΚ		18. Mother's	Name (First, Mide	dle, Maide	n Surname)	0SEP	Н
<u>}</u>	Menid I Menidan Marka Marka	ဥ	The second secon		-							
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan I Heath and Mental Hygiene 1 Heart 20 Is markental Hygiene 27 Is markental Hygiene 1 Heart 27 Is marked other than "netural", or Itams 23a or 28a-1 show other traumatic event, the Medical Eventiner must be notified at		19a. Informant's Name/Relationship (Type MRS. HELEN P.CHERNA		712	Mailing Address <i>(Street</i> 21 PARK HEI	GHTS AV	/E #808 B	ALTI	MORE, MD	. 21	215
ē,	is 1 and of Health item 27 other to	1 30	20a. Method of Disposition	20b. P	lace of learn	Disposition (Name of crematory or other pla	ice)	Date	1	ocation - City		State
altimore,	Pages ment of ant: If it ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Ren '4 ☐ Donation 5 ☐ Other (Specify)	BET	H T	ILOH CONG.	i	13/2004		OLAWN,M		
Balt	permit. Pages Department of I Important: If it eny injury or o		21. Signature of Funeral Service Licensee	C-41.		22. Name and Addre	ess of Facility	OL LEVIN	SON 8	& BROS.	INC	
	an 2 6 a		23a Part 1 Enter the disease or complica	tions that caused the death	h. Do ni	8900 REIST				ILLE,M		
	Dhumining		Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final	cause on each line.	2	lock		,	2.700.1		Inte	proximate erval Between set and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a conseq	uence o	NOCK TO THE REAL PROPERTY OF THE PERTY OF TH					0	days
	Examiner		Sequentially list conditions b.	Prieuu	W	nia					6	days
	sit s	iner	Sequentially list conditions, I any leading of in rediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conset	rende d	ŋ:					i i	0
•	be executed sician and burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a conseq	neuce o	r):					-	
760,	ite be executed ysician and ne burial-transit	calE	d									
89		edi	IF FEMALE:						1	-		
.O. Box	ath ce ttendii or use	lan/	23b. Was decedent pregnant in the past 12 months?	. If yes, outcome of pregna 1☐Live birth 2☐Feta	l death	3 ☐Ectopic pregnanc	y			23d. Date of o	elivery Day	Year
<u>.</u>	The law requires that the death certifical lite has been signed by the attending phoage 2 should be detached for use as the	by Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of de 9 Unknown	eath	5 Other (specify)			-		,	
م	that the the the the the the the the the th	y Ph	Part II. Other significant conditions contri	buting to death but not res	ulting in	the underlying cause gr	ven in Part I.	23e. Di	d tobacco	use contribute	to the ca	use of death?
rds	quires in sign	q pa	Non STelevatio	n Myoca	181	al lufar	ction	1[Yes 2	X № 3□	Probably	4 Unknown
ဝ၁	law re as bee 2 sho	piet	Acute on Chro	m'c Rem	2(Faiher	92	24a. W	as an topsy	24b. Were	autopsy f	indings available
ř =	The cate ha	Completed							rformed?	death	2	
Vita Vita	ician: sertific ector,	Be	25. Was case referred to medical examiner?	enital: -4		0#	300	Death (Check onl				
ō	Phys rthis raldit	7.	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outp 28b. Ti	ALIGHT 3 DOA	4 🗆 INUISII	ng Home 5 ☐ Re 28d. Describ			ecify)	
on	tending Physician: The lav Jeath. tor: After this certificate has the funeral director, page 2	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Inj	ury Wo	rk?]Yes 2.∏No			,		
Division of Vital Records,	r Atter	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide	28e. Place of Injury - At he building, etc. (Specifi	ome, farr	n, street, factory, office			(Street a	nd Number or	Rural Roi	ute Number,
	oitel o urs aft irel Di							N.		·		
	a Hosp 24 ho a Fune etely f	Medical	29a. Certifier 1 Certifying Physic (Check only 2 Medical Examine one)	ian: To the best of my kno r: On the basis of examina and manner stated.	wledge, tion and	or investigation, in my	opinion, death o	occurred at the tim	e, date an	d place, and d	as stated ue to the	cause(s)
	To the Hospitel or Attending Physicien: whith 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director.	Me	29b. Signature and title of certifier	C n = 1	^	29c. Licens	se number		29d. Da	ite signed (Mo	nth, Day,	Year)
	1.		> Galriela	Bull 1	W)	KE	7-01	00	JAA	1:11,	200	4
	10		30. Name and address of person who com	oleted cause of death (Item	23a) (T	ype, Print)	411	R DA		(/		
		•	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	401 HOTE	121 0+	00 balti	usig			
	Sta Registr	_	JAN 1 4 2004	A SUPERIOR AND AND AND AND AND AND AND AND AND AND	50	A so						

DHMH 17 Rev 1/2001

of Kenny os SiDNEY 4. CHERNAK

		1 - For AMEND ITEM #23a	State of Manyland/2	Pepartment of Certificate	of Health and N of Death	Mental Hygien Reg. N	e 2004	00622
√		Decedent's Name (First, Middle, Last	"			2. Date of Death Month	ay Yeer	3. Time of Death
Physic /Medi		John A.	Dunlop			1 - 1	2 2004	10:00 P.M
Exami		4a. Facility Name (If not institution, give	street and number)	4b. City, Tov	vn, or Location of Death	4	c. County of Death	
		1991 Greenba		pirthday) If Under 1 Y	ear If Under 24 Hrs.	8 Date of Birth	9 Birthol	ace (State or Foreign
Funeral Director		5. Sociel Security Number 6. Se	M 2 F 95		ays Hours Min.	8. Date of Birth (Month, Day, Yea	908 Dell	"YOCK.
		Usuel Residence of Decedent				1 1 - 30	700 171000	
nylan how		10a. State 10b. County	10c. City, To	wn or Location			10	od. Inside City Limits 1
ith the Marylan or 28e-f show	cto	MD		BALTIMO		100.0	Citizen of What Count	
with th	5	10e. Street and Number	DA.	10f. Zip Co	7170	log. c	/ 15 /	iy i
eath y	Funeral Director	1991 GREENE	12. Was Decedent Ever in U.S.	13. Was Decedent	of Hispanic Origin? (Sp Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - America	
fler d	Fun	1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give	1	/	Rican, etc.)	Black, White, e	itc.
iled within 72 hours after death with the Maryland Hygiene. Hygiene. ther then "natural", or Items 23s or 28s-1 show ont, the Medical Examiner must be notified at	þ	3 Widowed 4 □ Divorced	If Yes, Give \ Year or Dates:	1 □ Yes 2 🔀	No Specify:		Specify: W	1140
72 hc	Completed	15. Decedent's Edu (Specify only highest grad		ia. Decedent's Usual O (Give kind of work d life. DO NOT use n	fone during most of worl	kina	Kind of Business/Ind	ustry
within 15.	dE.	Elementary/Secondary (0-12)	College (1-4or 5+)	eacher.	PREDISTO	riv Po	riustai Lutenhoù	Tost
Hygir Hygir		17. Father's Name (First, Middle, Last)		cac is	18. Mother's Nam	e (First, Middle, Maide	on Sumame)	
lid be lental ked o	To Be	Peter Du	onlop		Mior	rie Sh	are	
Dattillore, Mal yially LICE 35-0050 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Menial Hygiene. Inspirate if item 27 is marked other then "natural", or items 23e or 28e-1 show may pointry or other traumatic event, the Moulcal Exemitre must be notified at pages.		19a. Informant's Name/Relationship (T	ype, Print) 19	9b. Mailing Address (St	treet and Number or Ru	ral Route Number, City	or Town, State, Zip	Code)
C, K		Marion C. M	alcolm. 1	991 Gree	enberry	Date 20c.	1MOVE 1	NO 21209.
Pages 1 nent of H ant: If ite		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ I	Removal from State	of Disposition (Name of tery, crematory of other	polace) Jak	1 14	Location - City or To	WII, State
DEALLITING permit. Pag Department Importent: I eny injury o		' 4 □Donation 5 □ Other (Specify	(EVANS	SFUN BRALC	HAPELT 20		ZEST HIL	L. 1710
Deart. Departr Import		21. Signature of Funeral Service Licens	(12)	OENCE I	address of Facility You		NERALIC	PEMATINA
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	ications that caused the death. D	o not enter the mode of	f dying, such as cardiac		TOUR TO THE	Approximate Interval Between
Physician		Immediate Cause (Final	The cause on each line.	monia	ASPIRATION I			Onset and Death
/Medical		disease or condition resulting in death)	Due to (or as a consequence	e of):	ADI HALLON I	THE STATE OF THE S		-
Examiner		Sequentially list conditions.	b. 15p	ration				
Si ad	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	e of):				
xecute and II-tran	Examlner	that initiated events resulting in death) Last	c Due to (or as a consequence	e of):				
BOX 001 00, eath certificate be executed attending physicien and Ifor use as the burial-transit	cal E		d					
oo iificate g phy as the			-					
th cert	an/N	23b. was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea	ith 3 □Ectopic pregr	nancy		23d. Date of deliver	ry Day Year
. 9	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of death 9☐Unknown	5 Other (specif	fy)		11101111	Ju, 102.
ecords, F.O. law requires that the de as been signed by the a 2 should be detached		Part II. Dther significant conditions co	ontributing to death but not resulting	g in the underlying caus	se given in Part I.	23e. Did tobacc	use contribute to th	e cause of death?
dS, uires i signe d be	d by					1 ☐ Yes	2 No 3 Proba	ably 4 Unknown
w requires t been sign should be	lete					24a. Was an	24b. Were autop	sy findings available
The law	Completed					autopsy performed? 1 ☐ Yes 2 ☑ 1	death?	pletion of cause of 2□ No
VICAL icien: 1 certifice ector, p	BeC	25. Was case referred to medical				th (Check only one)		
OT VITA Physicien: ribis certific ral director,	ToE	examiner? 1 Yes 2 No		Outpatient 3 DOA	Other: 4 Nursing H)
		27. Manner of Death	(Month, Day Year)	o. Time of 28c.	Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred	
ing P where		Natural 5 ☐ Pending		IVI	1 165 2 100		and Number or Rural	Poute Number
ISION C ttending P death. tor: After t	ation:	2 Accident investigation 3 Suicide 6 Could not be		farm street factory of	ffice	28f. Location (Street		
UNISION C I or Attending P after death. Director: After t I in by the funera	ation:	2 Accident investigation		farm, street, factory, or	ffice	28f. Location (Street City or Town, Sta		Houle Humber,
UIVISION cospitel or Attending Phours after death. unerel Director: After the filled in by the funera	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify) ysician: To the best of my knowled	dge, death occurred at t	the time, date and place	City or Town, Sta	(s) and manner as sta	ated.
UIVISION C the Hospitel or Attending P in 24 hours after death. the Funerel Director: After t spletely filled in by the funera	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only one) 2 Medical Exam	28e. Place of Injury - At home, building, etc. (Specify)	dge, death occurred at t and/or investigation, in	the time, date and place my opinion, death occu	City or Town, Sta , and due to the cause rred at the time, date a	ate) (s) and manner as stand due to	ated. the cause(s)
	ation:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify) ysician: To the best of my knowled niner: On the basis of examination	dge, death occurred at t and/or investigation, in 29c. L	the time, date and place my opinion, death occu icense number	City or Town, Standard, and due to the cause rred at the time, date a	(s) and manner as stand place, and due to Date signed (Month, L	ated. the cause(s)
To the Hospitel or Attending P within 24 hours after death. To the Funerel Director: After t completely filled in by the funeral	Certification;	2 Accident 3 Suicide 4 Homicide 29a. Certifier (Chack only one) 29b. Signature and title of certifier	28e. Place of Injury - At home, building, etc. (Specify) ysician: To the best of my knowled inner: On the basis of examination and manner stated.	dge, death occurred at tand/or investigation, in	the time, date and place my opinion, death occu icense number	City or Town, Standard, and due to the cause rred at the time, date a	(s) and manner as stand place, and due to Date signed (Month, L	ated. the cause(s)
DIVISION C To the Hospitel or Attending P within 24 hours after death. To the Funerel Director: After t completely filled in by the funeral	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only one) 2 Medical Exam	28e. Place of Injury - At home, building, etc. (Specify) ysician: To the best of my knowled inner: On the basis of examination and manner stated.	dge, death occurred at tand/or investigation, in	the time, date and place my opinion, death occu icense number	City or Town, Standard, and due to the cause rred at the time, date a	(s) and manner as stand place, and due to Date signed (Month, L	ated. the cause(s)
1	Certification;	2 Accident 3 Suicide 4 Homicide 29a. Certifier (Chack only one) 29b. Signature and title of certifier	28e. Place of Injury - At home, building, etc. (Specify) ysician: To the best of my knowled inner: On the basis of examination and manner stated.	dge, death occurred at the and/or investigation, in 29c. L. D.C. a) (Type, Print)	the time, date and place my opinion, death occu	City or Town, Standard, and due to the cause rred at the time, date a	(s) and manner as stand place, and due to Date signed (Month, L	ated. the cause(s)

		•	For State Registrar	State of Maryland	d / Departi			Mental Hygie	71111	00623
>	Physicia /Medic Examin	al	Decedent's Name (First, Middle, Last) LE 4a. Facility Name (If not institution, give s	TE T preet and number) AN HOGPITA	al E	Bal tiv	Location of Dea		Day Year 10, 200 4c. County of Dea	ath
* 0	Funeral Director		5. Social Security Number 6. Sex 216-20-3392	7. Age (In yrs. la		Under 1 Year onths Days	If Under 24 Hrs Hours Min			rthptace (State or Foreign ountry) Maryland
	Maryland I-f ehow	tor	10a. State 10b. County MD Baltimo		Town or Location	on				10d. Inside City Limits 1 ☐ Yes 2 🖔 No
	h with the	Funeral Director	10e. Street and Number 3900 Longmoor Cir	cle	1	01. Zip Code 21131			. Citizen of What C United St	
036	be filed within 72 hours after death with the Maryland at Hygiene. A let Hygiene of the than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examinat must be notified at	ρ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	2. Was Decedent Ever in U.S Armed Forces? 1			ispanic Origin? (! n, Mexican, Pue Specify:	Specify Yes or No- no Rican, etc.)	14. Race - Am Black, Whi Specify:	
Maryland 21215-0036	filed within 72 ho Hygiene. Sther than "natur. ent, the Medical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		16a. Decedent (Give kind life. DO	d of work done o NOT use retired	during most of wo	nrking 16t	b. Kind of Business	
yland		To Be C	17. Father's Name (First, Middle, Last) Eugene Aloysius	McGrail			Margare		Wess	
	1 and 2 s Health ar Hem 27 is other trau		19a. Informant's Name/Relationship (Ty) Margaret Ann Kelly 20a. Method of Disposition	/sister		alencia on (Name of	Drive	Ormond Bea Date 200		ida 32176
altimore,	t. Page rtment o rtant: If rjury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Figneral Service Lights	Hill	top Svo	. Corp.	01/1	+/2004		Maryland Home, Inc.
) B	Depar Impo Impo eny ir		23a. Part 1. Enter the disease, or complishock, or heart failure. List only on	MOIIZZ	105	O York	Road To	owson, Mary	yland 2	21204 Approximate
760,	Physician // Medical Examiner prize partial-transit	Ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last	Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	ence of):	nia nia	herel	Vascula		Interval Between Onset and Death
O. Box 68	The law requires that the death certifical ate has been signed by the attending phypage 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnan 1□Live birth 2□Fetal 4□Pregnant at time of de	death 3□Ect	opic pregnancy her (specify)			23d. Date of de Month	elivery Day Year
مٰ	quires that the signed by all be detacted		Part II. Other significant conditions con	tributing to death but not resul	lting in the under	rlying cause giv	en in Part I.			to the cause of death? Probably 4 Munknown
al Records,	n: The law requir. Icate has been si r, page 2 should I	Completed							d?/ prior to death?	utopsy findings available completion of cause of
Division of Vital	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No F 27. Manper of Death 1 Natural 5 Pending 2 Accident investigation	1	28b. Time of Injury	3 DOA Oth 28c. Injur	er: 4□ Nursing	Home 5 Residence 28d. Describe how		acify)
Divis	al or Atter s after dea il Director d in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)		factory, office		28f. Location (Stree City or Town, S		Rural Route Number,
7/	To the Hospital or within 24 hours after To the Funeral Direction completely filled in the funeral filled in t	Medical (sician: To the best of my knowner: On the basis of examinati and manner stated.						
	Tathe within 2 Tathe complete	2	29b, Signahire and title of certifier	J. Ja	2	29c. Licens	927	0	Date signed (Mon	oth, Day, Year)
7	Sta	ate	30. Name and address of person who come of the Mark Community of the Mark 20	the same of the same of		NEN SEL	Blvd.	Baltin	nore :	21239

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Edward Andrew January Doehler 7:30 A M 12, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Stella Maris Timonium Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Merch 9, 1909 9. Birthplace (State or Foreign Country)
NEW York **Funeral** 1**X** M 2 □ F 94 Yrs. 215-03-0693 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If Item 27 Is marked other than "natural", or Itema 23s or 28a-1 show any injury or other traumatic event, to Medical Examinating Instituted at once. 1 ☐ Yes 2√ No Directo Timonium Maryland Baltimore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 2300 Dulaney Valley Road Unit M 312 21093 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 X Married Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify: Specify: δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+)
5 + Elementary/Secondary (0-12) History Professor Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph A. Doehler Elizabeth Engelhardt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2300 Dulaney Valley Road Unit M 312 Timonium, Maryland 21093 Mrs. Catherine Doehler (Wife) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Most Holy Redeemer Cemetery 1/14/2004 Baltimore Maryland *4 Donation 5 Other (Specify)

21. Signature of Forers Service Lines > 22. Name and Address of Facility Ruck Tawson Funeral Home, Inc. 1050 York Road Tawson, Md. Monace 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Est only one cause on each line. Approximate Interval Between Onset and Death 105/1 Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of). The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760. physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown ۵. Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 Nnknown Be Completed ME/spacis 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 certificate has 1□ Yes of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 10 Medical Certification; To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Division Attending 1 ANatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death Director: A 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral C 29a. Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature at 29c. License number 29d. Date signed (Month, Day, Year) 15504 06. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093 EDDIE NAKHUDA, M.D. 32. Registrar's Signature 31. Date filed With Part YEAR 14 State Registrar

7:30

JANUARY

EDWARD

DOEHLER,

ANZ, norma 8:15P 1/12/04

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death January 12, 2004 **Physician** 8:15рм Norma Ε. /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Pickersgill Towson If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Pear 1918 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2**X**F Maryland 85 218-05-9327 Director Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r then "natural", or Items 23a or 28e-f show the Modical Examinar must be motified at Md. Baltimore Towson 1 ☐ Yes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21204 USA 615 Chestnut Ave. Funeral filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 🖔 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 le markad othe any light yo other treumatic event, 90se. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mildred Johnson Ralph Truitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. John G. Danz, Sr./ Husband 615 Chestnut Ave. Towson, Md. 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Mays Chapel Cemetery 1-16-04 timonium, Md. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Towson Funeral Home, York Rd. Towson, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician zarsi 1000 resse /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner physician and s the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year 5 Other (specify) 9☐ Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? eneration 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 XNo 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) Medical Certification: To 1 Tyes 2 No After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred 27. Menner of Death 1 Natural 2 Accident 5 Pending hours after death. unerel Director: After sly filled in by the fun-1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel (29a. Certifier 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hales St. Bolfa MI Zizox FB. 31. Date filed (Mont) PM Y ar # 2004 32 Begistrate Signature State

DHMH 17 Rev 1/2001

Registrar

			State of Maryland / Department of H 1- State Registrer Certificate of I			iene 2001	00626
			Decedent's Name (First, Middle, Last)		2. Date of Deat	h	3. Time of Death
	Physic /Medi		EDNA MARLENE DINGEE		January	Day Year 11, 2004	5:10 pm ^M
	Exami			r Location of Death		4c. County of Dea	
				sboro		Washin	gton
.	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,		hplace (State or Foreign buntry)
	Director		220 - 28 - 3256 The state of Decedent To To The state of Decedent To To The state of Decedent To To The state of Decedent To To To To To To To To To To To To To		June 27	,1933 Ma	ryland
	land ow		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	the Marylar 28e-f show	ğ	Maryland Washington Boonsboro				1 XYes 2 No
	vith the Maryla or 28e-f shov	irec	10e. Street and Number 10f. Zip Code		10	0g. Citizen of What C	ountry?
2	23a c	aiD	141 South Main Street 217	13		U.S.A.	
	after dea or Items	Iner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Spec an, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
dna	S affe	by Funeral Director	1 ☐ Never Married 2 【X Married 1 ☐ Yes 2 【X No If Yes, Give 1 ☐ Yes 2 【X No Year or Dates:	Specify:		Specify: W	nite
न्त्र ह	I Z I 3-UU30 within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show than "natural" are interested by the model of the mode	ed b	15 Decedent's Education 16a, Decedent's Usual Occup	pation		16b. Kind of Business	/Industry
إلا	ZID thin 72 e	piet	(Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired.) Elementary/Secondary (0-12) College (1-4or 5+)	during most of workin	ng		
7	d with giene.	Completed	3 Registere	d Nurse		Hospita	1
2) -	₽	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, N	Maiden Sumame)	
96	arylar, should be and Mental s marked c	2	Elmer Ellsworth Sny <u>der</u>	Mary	Kath		ardner
9	Alary	1	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street				
	ore, Maryla s 1 and 2 should of Health and Men item 27 Is marke other traumatic		Donald R. Dingee Husband 250 Avon Road 20a. Method of Disposition (Name of	Da	own, Ma	ry Land 217 20c. Location - City or	Town, State
			1 🔀 Burial 2 Cremation 3 Removal from State			· · ·	ng, Maryland
کی :	EXALTIMOTE permit. Pages 1 a Department of He Importent: If iten any injury or oth		722	- 1			
Name	Departiment any ir	1	R. hael Brady 40 Fast Ar	torrman F ntietam St	reet H	Home, Inc.	Md. 21740
2			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dyin shock, or heart failure. List only one cause on each line.	ng, such as cardiac or	respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	eide A			Onset and Death
	/Medical		resulting in death) a. Due to (or as a consequence of):	cery		·	minus
.1.	Examiner		Sequentially list conditions, b.				
y h	Sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause, (Disease or Injury)				
V	executed executed in and ial-transit	xam	resulting in death) Last Due to (or as a consequence of):				
9	Pri B						
Ġ	the state of the s	edicai	0.				
	BOX 6 Bath certific attending p for use as	Z	IF FEMALE: 23b. Was decedent pregnant 1☐Live birth 2☐Fetal death 3☐Ectopic pregnancy			23d. Date of de	•
	death death	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) _	,		Month	Day Year
(at the	h Š	9 Unknown		Oca Did tak	pacco use contribute t	the series of death?
	DIVISION Of VITAI HECONDS, P.O. BOX 61 To the Hospital or Attending Phyaician: The law requires that the death certific within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as it	ě	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	en in Part I.	23e. Dia tob	_/	robably 4 Dunknown
	requirements	Completed			24a. Was ar		utopsy findings available
	Hec ne law has l	mpi			autops	y prior to death?	completion of cause of
	all		OF Was also related to modical	GE Pines of Death			2 □ No
	VIII aicia centi	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Oth	26. Place of Death		nce 6 □Other (Spe	city)
	g Phy er this	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury			w injury occurred	
	nding ath. r: Aft	atio	2 Accident investigation M 1	Yes 2□No			
	DIVISION I or Attending after death. Director: Afte	ertification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	2	8f. Location (Sti City or Town	reet and Number or R n, State)	ural Route Number,
	Dital o	O					
	Hosp 24 hou Fune stely fi	ledical	29a. Certifier Check only One) Certifying Physicien: To the best of my knowledge, death occurred at the tire Check only Medical Examiner: On the basis of examination and/or investigation, in my of and manner stated.	me, date and place, a opinion, death occurre	and due to the ca ad at the time, da	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	o the ithin (Me	29b. Signature and title of certifier / 29c. Licens	se number	25	9d. Date signed (Mon	h, Day, Year)
	⊢ ≯ ⊢ ō			12518		1/12/04	
	_		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				
	3		Dr. Robert Guedenet 21 Wyand Drive, Keedysvil	le, Maryl	and 2175	56 / 301-4	32-2222
	Si Regis	ate trar	31. Date filed (Month, Day, Year) JAN 1 4 2004 Registrar's Signature				

		for State	Type or Print State of Man	/land / Depa		Health and Me	ntal Hygie	ene 2001	0000
Phys		Registrar 1. Decedent's Name (First, Middle, Lass ROSINA	M	a. a.	GUISEPPI		P. Date of Death Month JANUARY	Day Year	3. Time of Death
	dical niner	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Death EN BURNIE	JANOARI	4c. County of De	ath
Funer Direct		153-18-7457	7. Age (// □ M 20XF 87	n yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Day, Y 10/3/191	9. B	irthplace (State or Foreign Country) NJ
faryland show	- -	Usual Residence of Decedent 10a. State 10b. County MD ANNE AR		Oc. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 22 No
with the A Sa or 28a-	Direct	10e. Street and Number 5 GLENMONT AVEN		GUEN	10f. Zip Code 2106	1	10g	. Citizen of What (Country?
DESILIMOTE, INIGITY ISING Z I Z I 3-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic swent, the Medical Experiment must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married XX Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates:	l l	Was Decedent of H	Hispanic Origin? (Speci an, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - An Black, Wh	
21215-0036 Id within 72 hours at giene. In then "natural", or the Medical Exam.	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Give	lent's Usual Occup kind of work done DO NOT use retire	during most of wadding	16	b. Kind of Busines	s/Industry
and ziz	Be Com	17. Father's Name (First, Middle, Last)	College (1-4or 5+)		IEMAKER	18. Mother's Name (OWN HOME	
Maryland nd 2 should be file lith and Mental Hy 27 is marked oth r traumatic sveni	-To-	19a. Informant's Name/Relationship (I	ype, Print)			and Number or Rural F	Route Number, C		
Saltimore, Dermit. Pages 1 ar Department of Hea Important: If Item Any injury or othe	1	20a. Method of Disposition 1 ☐ Burial XX Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify	Removal from State	20b. Place of Dispo- cemetery, crem BAYVIEW C	natory or other pla			c. Location - City o	
Dalt permit. Departitimports	SUCE	21. Signature of Funeral Service Licen			Name and Addre	HWY., S, C		AL HOME, NIE, ND 2	
Physicia /Medic Examine	al	23a. Part 1. Enter the disease of ching shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	h ations that caused the e cause on each line. a. Rendl Due to (or as a co	failer	er the mode of dying	ng, such as cardiac or r	espiratory arrest		Approximate Interval Between Onset and Death
be executed be executed sicien and burial-transit	at Examiner		b. Due to (or as a co	ensequence of):					10 gars
that the death certificate of by the attending physis detached for use as the the total control of the terms.	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ ¥o 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	1		23d. Date of de Month	elivery Day Year
THECOIDS, P.O. The law requires that the steep signed by the page 2 should be detached.	þ	Part II. Other significant conditions of	ontributing to death but no	ot resulting in the un	iderlying cause giv	en in Part I.	23e. Did tobac		to the cause of death? Probably 4 Unknown
II KECOLUS, The law requires the law been signed page 2 should be or	Completed						24a. Was an autopsy performed 1 ☐ Yes X2X	prior to death?	autopsy findings available completion of cause of
ysician: The l ysician: The l is certificate ha	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2XXIo	Hospital:	2 ER/Outpatient	t 3□ DOA Oth	26. Place of Death (Coer. 4 Nursing Home		6 CON-1/C-	
ding Ph After th funeral	I		28a. Date of Injury (Month, Day Ye	28b. Time of	28c. Injur Wor	y at k? Yes 2 \(\bar{\text{No}} \) No	d. Describe how i		өспу)
LIVISION ITALICATION Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (5	At home, farm, stre	eet, factory, office	28f	. Location (Stree City or Town, S	t and Number or F tate)	Rural Route Number,	
To the Hospital of within 24 hours at To the Funeral D completely filled in	edical	29a. Certifier MCertifying Phy	vsicien: To the best of m iner: On the basis of exa and manner stated.	amination and/or inv	occurred at the tin estigation, in my o	ne, date and place, and pinion, death occurred	due to the caus at the time, date	e(s) and manner a and place, and du	is stated. The to the cause(s)
To t To t	×	29b. Signature and title of certifier	ul my	Ь.	29c. Licens	e number	29d.	Date signed (Mon	ith, Day, Year)
6		30. Name and address of person the of Stephen Zemel	M-D: 1831	8 Greene	Tree Ro	(#245 B	altino	ano.	21208
	State strar	31. Date lied (Marth, Day, Year) 1004	2. Registrar's	Signature	K)			,	

DHMH 17 Rev 1/2001

DiGwiseppi, Rose

1 -C	288			State of Marylan				-	
			1 - For Unpend Item #23 Registrar		G828 2/5/04 Certific	tas ate of Death		2004	00628
	Physici		1. Decedent's Name (First, Middle, La	aron Fllis	3		2. Date of Death Month JANUARY	11, 2004	3. Time of Death
E	/Medic Examin		4a. Facility Name (If not institution, giv		4b. C	ity, Town, or Location of Death		Ic. County of Death	<u> </u>
			3706 W. COLDSPRI			LTIMORE CITY der 1 Year If Under 24 Hrs.	R Date of Birth	NH	place (State or Foreign
	Funeral Director		5. Social Security Number 6. S Usual Residence of Decedent	M 20F 45	Yrs. Mont		8. Date of Birth (Month, Day, Yea	59 600	made (State of Poreign
	he Maryland 88-f show	ector	10a. State 10b. County	10c. Ci	ty, Town or Location	Himore	10-7		10d. Inside City Limits 1 Yes 2 □ No
	ath with t	Funeral Director	3706 W. Cold	spring Lar	re	21215		USA	
920	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other then "natural", or items 23s or 28s-f show other traumatic event, the Madical Extender main be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decement Ever in U Armed Porces? 1 □ Yes 25 No If Yes, Give Year or Dates:	If Yes,	cedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto s 27 No Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Amer Black, White	
21215-0036	ithin 72 ho ne. hen "natur e Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ide completed) College (1-4or 5+)	16a. Decedent's U (Give kind of life. DO NO	work done during most of work Tuse retired)	king 16b.	Kind of Business/I	Oto Con i
	uld be filed w fental Hygie rked other t tic event, th	Be	17. Father's Name (First, Middle, Last	FILIS	<u>ur</u>	18. Mother's Nam	ne (First, Middle, Maid	en Sumame)	Conferry
Maryland	2 should and Me is mark sumation	오	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Addr	ess (Street and Number or Ru	ral Route Number, City	Los Town, State, Zi	p Code)
_	ges 1 and 2 at of Health a li item 27 is or other tra		20a. Method of Disposition 128urial 2 Cremation 3		Place of Disposition (cometery, crematory	V. CONSPIU Name of or other place)	Dale 20c.	BOITU. Location - City or T	70 21215 Own, State
Baltimore,	permit. Pages Department of I Important: If it eny injury or o once.		4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice	v) Hr	DUTUS C 22. Name	emetery 01-1	6-04 K	Greens	re MD
b	403.4		23a. Pert1. Enter the disease or com shock, or heart failure. List only	plications that caused the dear	th. Do not enter the r	node of dying, such as cardiac	or respiratory arrest,	21'to. 111	Approximate Interval Between Onset and Death
*	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Seizure Disor Due to (or as a consec					Onset and oscilla
	ted sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consec	quence of):				
,092	te be executed ysician and te burial-transit	cal	that indiated events resulting in death) Last	Due to (or as a consec	quence of):				
.O. Box 68	that the death certificate bed by the attending physic detached for use as the b	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of c 9 ☐ Unknown	el death 3 Ectopi	c pregnancy (specify)		23d. Date of delive	very Day Year
s, p	es De pe	by Ph	Part II. Other significant conditions		sulting in the underlying	g cause given in Part I.			the cause of death?
ord	w requir been si should	eted	Hypertensive Cardio	vascular Disease					bably 4 DUnknown
of Vital Record		Completed	OF West and referred to marked			20.21. (2	24a. Was an autopsy performed?	prior to co	opsy findings available ompletion of cause of 2 □ No
Z.	d is	o Be	25. Was case referred to medical examiner? 1 ★ Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□	0.4	th (Check only one) ome 5 Residence	6 ☑ Other (Speci	(y) AT SCENE
	fter	ertification; T	27. Manner of Death 1 XNatural 5 Pending 2 Accident Investigation		28b. Time of Injury M	28c. Injury at Work?	28d. Describe how in		ALIXIA
Division	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: All completely filled in by the fu	Certific	3 ☐ Suicide 6 ☐ Could not to determined		ome, farm, street, fac fy)	tory, office	28f. Location (Street City or Town, Sta	and Number or Rur ife)	al Route Number,
	e Hosp 24 hou e Funel letely lii	Medical		nysician: To the best of my knominer: On the basis of examination and manner stated.					
)	To th within To th	Me	29b. Signature and title of certifier	ms		29c. License number OCME		Date signed (Month, NUARY 12,	
			30. Name and address of person who			Street, Baltim	oro Mowell	and 21201	
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Sign			re, ratyle	1144 CIZUI	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Kenneth Robert Fuchs 1:05 P M January 11 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1837 Clark Boulevard Relay Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days 1 M 2□ F 63 Director 217-38-0702 Maryland 10, 1940 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show empiripary or other treumatic event, Ita Modical Examination with De notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Baltimore Relay 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1837 Clark Boulevard 21227 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. tXTYes 2 □ No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White à Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Receiving Clerk Coca-Cola 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Kenneth W. Fuchs Frances Roberts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherry Fuchs - Sister In Law 21805 Langdon Farm Road Sherwood, Maryland 21665 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Grace Episcopal Cem. 1/15/04 Elkridge, Maryland *4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home At MMP., Inc. 7250 Washington Blvd. Elkridge, Maryland 21075 $m\omega \sim$ 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) metastation **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentiary fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 sesidence 6 Other (Specify) ို 1 ☐ Yes 2 No filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No Director. 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Sign (ture and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 30, Name and address of person who completed cause of death (item 23a) (Type, Print) BALTIMORE MA 19/11/61 arole 0 "atona 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 1 4 2004 acorte

			1 - For State Registrar	State of Ma	ryland .				ealth a	and M		Reg. No.	200		0630
	Physicia	20	1. Decedent's Name (First, Middle, Las								Date of Dea Month	ath Day		1 . 4	of Death $5 p \cdot M$
	/Medic		1	Luther	L.Ge	nus		T	l d'	4 D - 44	11	4	2004 County of Dea		
)	Examin	er	4a. Fecility Name (If not institution, give					nown, or alti	Location o	or Death			N/A	2(1)	
			3001 Glen Aver 5. Social Security Number 6. S		(In yrs. lasi	t birthday)		1 Year	If Under		8. Date of Birt (Month, Da		9. Bi	thplace (Sta	te or Foreign
	Funeral Director			À M 2□F	57	Yrs.	Months	Days	Hours	Min.	(Month, Da 12-18	y, Year) 1–194	0	ouintry) ` Tex	
15.	-		Usual Residence of Decedent												
	rylan show		10a. State 10b. County		10c. City, T	Fown or Loc	cation								e City Limits 'es 2 ☐ No
	Be-1-	Director	Md N/A	1	Ba1	timor						10- 02	zen of What C		
	or 2	Dire	10e. Street and Number				10f. Zip		-					ountry	
	s 23s	Funeral	3001 Glen Avenu	12. Was Decedent E	ver in U.S.	13 V	l l	2121.		gin? (Spe	cify Yes or No		J S A 14. Race - Am	erican Indian	
	Item de	Š	11. Maritał Status 1 ☐ Never Married 2 ☒ Married	Armed Forces?							cify Yes or No Rican, etc.)		Black, Wh	_	
5	urs af	ρ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1	I □ Yes	2 ∑ No	Specify:				Specify: B	lack	
5	within 72 hours after death with the Maryland ene. Than "natural", or llems 23a or 28e-f ehow he Madical Examiner man the natities at	Completed	15. Decedent's E (Specify only highest gra	ducation		16a. Deced	lent's Usu	al Occupa	ation during mos	t of workir	na	16b. Ki	nd of Busines	s/Industry	
7	thin 1	nple	Elementary/Secondary (0-12)	College (1-4or 5-					turing mos			Pr	estige	Auto	
Maryland 21215-0036	filed wi Hygien other th	ပ်	12th grade		N/A	Serv	ice	Rep	19 Mothe	ar's Name	(First, Middle,				
ב	Hal H od oth	Be	17. Father's Name (First, Middle, Last Zimmie Genus	,					Lean		(First, Middle,	Maideri	Sumame)		
2	should Ind Men	2	19a. Informant's Name/Relationship (Type Print)		19h Mailin	o Addres	s (Street a			l Route Numbe	er. City o	r Town. State.	Zip Code)	
ā Z	d 2 sho th and 7 is m treum						•					212		_,	
ď.	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-1 ehow amy injury or other treumatic event, the Macinal Examinar must be notified at any injury or other treumatic event, the Macinal Examinar must be notified at any injury or other treumatic event, the Macinal Examinar must be notified at ange.		20a. Method of Disposition	Vife	20b. Plac	ce of Dispos netery, crem	sition (Na	me of	enue	_ DAL	ro, MD		ocation - City o	r Town, State	,
Baltimore,	ages ant of it: If ii		XXBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special			rriso				1/14/	2004	Owi	ngs Mi	11s, M	d
┋	permit. Pages 'Department of h Importent: If ite eny injury or of		21. Signature of Funeral Service Lice								rch F/H				
B	Depa Impo eny ii		Muhin	DOX	a						n Avenu		alto,	Md 212	15
			23a. Par 1. Enter the disease, or comshock, or heart failure. List only	plications that caused one cause on each lin	the death.	Do not ente	er the mo	de of dyin	g, such as	cardiac o	r respiratory a	rrest,		Approxi	mate Between
	Physician		Immediate Cause (Final disease or condition	Myo	cardi	al.	In fo							Onset a	nd Death
	/Medical		resulting in death)	Due to (or as		nce of):				i					77.44
	Examiner		Sequentially list conditions.	U	hemi		ardi	omy	cpat	ny_				16	years
	p is	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	•		4.34.00.00.4	ا اس	CONTA	ر د				v 6	y ears
	eath certificate be executed attending physicien and for use as the burial-transit	Examln	that initiated events resulting in death) Last	c. Co Due to (or as	a conseque	nce of):	rery	4	عدداد				 		
760,	be exicien buria	calE	· ·	M	itral	R	egur	gita	ition					> 6	years
687	icate phys s the			_ d			- V	71							
×	Physicien: The law requires that the death certifical this certificate has been signed by the attending phraid director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			75-4						23d. Date of d	elivery	
Box	death e atte d for	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant at			Ectopic p Other (s						Month	Day	Year
0.0	that the de ted by the detached	hys	9 Unknown	9□ Unknown											
	es tha igned be del	by P	Part II. Other significant conditions		ut not resulti	ing in the u	nderlying	cause giv	en in Part	l.			use contribute		
ğ	v require been sig should b	ted	Typerte	nsion							10	Yes 2	⊠ No 3□F	robably 4	Unknown
ecc	e law re has be je 2 sho	Completed	Alcohol	Depende	eince						24a. Was auto	psy	24b. Were a	autopsy findir completion	ngs available of cause of
œ —	The ate h	Son		v							perfo 1 ☐ Yes	rmed? 2 🔼 No	death? 1 ☐ Ye		
of Vital Records,	ysicien: The is certificate hadirector, page	Be (25. Was case referred to medical examiner?	Uppoital				Oth		e of Death	(Check only	one)			
£	Physi this c al dire	မ	1 Yes 2 No	Hospital: 1 Inpatie	nt 2 El	R/Outpatier			4 🗀 141		me 5 🗷 Resi 28d. Describe			ecify)	
n C	ling F	o	27. Manner of Death 1 △Natural 5 ☐ Pending	(Month, Da)	Year)	Injury	м	28c. Injur Wor 1 □	k? Yes 2.⊡		Loa. Dodonisc	now inqui	, , , , , , , , , , , , , , , , , , , ,		
isic	death death ctor: / the	icat	2 Accident investigation 3 Suicide 6 Could not	De Blace of Init	ury - At hom	ne, farm, str					28f. Location (Rurai Route I	Vumber,
Division	lor A after Dire	Certification:	4 Homicide determined	building, et							City or To	wn, State)		
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical C	(Check only 2 Medical Exa	hysician: To the best miner: On the basis of	examinatio	ledge, deat on and/or in	h occurred vestigatio	d at the tir n, in my c	me, date a	nd place, a	and due to the ed at the time,	cause(s)	and manner and de	as stated. ue to the cau	se(s)
	the hin 2 the l	Med	one) 29b. Signature and title of certifier	and manner sta	100.		20	c. Licens	e number			29d. Da	te signed (Mo	nth, Day, Yea	ar)
	To To	-	240. Signature and title of certifier	c - 0	_	MD			556	98			anuary		
7			10	nomaloted at 1111	onth /4-= 5			000	000	, 0		70	7	, ,	
	2		30. Name and address of person who	ng MD.	eath (item 2	23a) (Type, Greer		t.	Balt	imo	re M	D	2120	1	
		ate	31. Date filed (Month, Day, Year)	4	ar's Signoatu						-			•	
	Regis			TI pon				0	~						

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 5:05 AM ELEANOR F. G. LORIOSO 01 12004 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BACTIMORE (1) GOOD SAMARITAN HOSPITAL BALTIMORE Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1□M 2以F 217-26-7953 Director Usual Residence of Decedent permit. Pegas 1 and 2 should be filled within 72 hours aftar death with the Maryland Department of Heelih and Mentel hyglene. Important: If Item 27 is marked other than "natural", or itema 23a or 28a-f ahow any highry or other treumatic event, the Medical Examinat must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Baltimo Re *tarkville* Funeral Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7914 2SA Jack Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12 Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□ Yes 200No Specify: White Baitimore, Maryland 21215-0020 Completed by 3XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) memaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) å Kichard 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Westmoreland 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 ☑ Other (Specify) 21. Signature of Femeral Service Licks the isease, or complications in caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, part failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician PNIEUMONIA., RESPIRATORY FAILURE Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner ettending physicien and for use as the burial-transit or Attending Physicien: The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown BLEED Be Completed by To the Hospital or Attending Physicien: The lew requires the within 24 hours efter deeth.

To the Funerel Director: After this cartificate has been signs complistaly filled in by the funeral director, page 2 should be. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? TO Yes 2LING 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 3 DOA Medical Certification: To 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier (ihomas) 00060687 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOOD SAMARIMAN HOSPITAL SOMY THOMASMO, M

DHMH 16 Rev 6/95

Registrar

31. Date filed (Month, Day, Year)

Keen J. Spectis

32. Registrar's **M**nature

Richard Duval 04-00291 RJ	L G		Fype or Prin State of Ma						-		_	
	1	For INPEND ITEM #23a, Registrar		PER ME	Certi	728/0 ficate	of Dea	th			. 2001	00632
Physician		Pecedent's Name (First, Middle, Last RICHARD DUVAL GO		H 3DI	D				2. Date of D Janua		1, 2004	3. Time of Death
/Medical Examiner		. Facility Name (If not institution, give		يار ودد		4b. City, 1	Town, or Locat	ion of Death	l	40	c. County of Deal	h
		1016 Larch Lane				ELI	DERSBUR	RG			Carroll	
Funeral	5.	Social Security Number 6. Se	x 7. Age	e (In yrs. las		If Under Months	1 Year If Un Days Hou	nder 24 Hrs.	8. Date of B (Month, D	irth ay, Yeer	9. Birt Co	hplece (Stete or Foreign
Director		16-44-1552 sual Residence of Decedent	-X	59	Yrs.				1/1/19	945	MA	RYLAND
yland	-	Da. State 10b. County		10c. City, 7	Town or Loca	ition						10d. Inside City Limits
e Mar lateral	3	MD CARROLL		ELI	DERSBU	RG						1 ☐ Yes 2 ☐ No
with the Mau a or 28a-f a be notified	10	De. Street and Number				10f. Zip					itizen of What Co	ountry?
sath v	8	1016 LARCH LANE	12. Was Decedent I	Ever in II S	13 Wa		784	Origin? (Sp	ecify Ves or N	US	5A 14. Race - Ame	rican Indian
State death variet death variet mas 23s process of the contract mas 23s.	5 ''	1. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 X X				ent of Hispanio rty Cuban, Mex		Rican, etc.)		Black, Whit	
hours after death with the Maryland tural; or Itams 23a or 28a-f ahow at Examiner must be notified at and by Eumeral Director	2	3 ☐ Widowed 4 X Divorced	If Yes, Give Year or Dates:		1 L]Yes 2	No Spe	city:			Specify: WH	ITE
5-0 72 ho natu	בופר	15. Decedent's Ede (Specify only highest grad	ucation le completed)		16a. Deceder (Give kii	nd of won	k done during i	most of work	ing	16b. I	Kind of Business/	Industry
21215-00 ed within 72 hou yejenen verthan "natura t, the Medical E	2	Elementary/Secondary (0-12)	College (1-4or 5	· _	rechnic	O NOT us				NOF	RTHROP G	RUNMAN
ind 2121 be filed within tal Hygien with a other than ' avent, the Me		7. Father's Name (First, Middle, Last)	IEARS		LECTIVIT	CAL_		lother's Name	e (First, Middle			
	2	RICHARD D. GOLDS	BOROUGH,	JR.			KA	THERI	V JEFFF	RIES		
laryla 2 should land and Men 1s marke summatic		9a. Informant's Name/Relationship (T	ype, Print)		19b. Mailing	Address	(Street and Nu	ımber or Run	al Route Numi	ber, City	or Town, State, 2	Zip Code)
ore, M. ss 1 and 2 litem 27 li	_	CHRISTIAN WILSON	FRIEND		139 N		IN ST.		306 E		AIR, MD	21014
Ages Into H	120	Da. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I		cem	etery, crema	tory or ot	her place)	1			A POST CO.	
Baltimore, permit. Pages 1 at Department of Hea Important: if Itam any injury or other any injury or other ance.	2	 4 □Donation 5 □ Other (Specify, Signature of Funeral Service Licens 		MEW C	CATHEDI 22. M		JEM. Address of F	111.	/2004		TIMORE,	
Bal permi Depa Impo		Heather v	1. Hule	-			OCH RAV	IHE				HOME, P.A. 286
	2	23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused	the death.							12	Approximate Interval Between
Physician	l d	mmediate Cause (Final			XIDE IN	TOXTC	ATTON					Onset and Death
/Medical Examiner	r	esulting in death)	Due to (or as									
The second	S	sequentially list conditions,	b. Due to for as	8 CONSHIQUED	nea : ft							
ecuted and transit	o C	ause. Enter Underlying ause (Disease or injury nat initiated events										
	, (e	esulting in death) Last	Due to (or as	a consequer	nce of):							
760 ate be nysicie ne bu	2		d									
Records, P.O. Box 68760, The law requires that the death certificate be exe ate has been signed by the attending physician a page 2 should be detached for use as the burian-	E IF	F FEMALE:		. 00.00								
BO)	2	3b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth 4☐Pregnant at	2 Fetal de	eath 3DE	ctopic pre				1	23d. Date of del Month	ivery Day Year
P.O. B. that the death that the death death defached for detached for Physicia	300	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	THE OI GOAL	N 200	Miei (Spe	city)					
ds, P. (Irres that the signed by d be detacted by the detacted by the detacted by the physical for the phy	P	art II. Other significant conditions co	ntributing to death b	ut not resulti	ng in the und	erlying ca	use given in P	art I.	23e. Did	tobacco	use contribute to	the cause of death?
Division of Vital Records, for Attending Physician: The law requires that death. Director: After this certificate has been signed in by the funeral director, page 2 should be certification: To Re Completed by	, _	CHRONIC ALCOHOL	ISM						1 🗆	Yes 2	2□No 3□Pr	obably 4 Unknown
al Record The law requir cate has been s page 2 should	<u> </u>								24a. Wa	s an	24b. Were au	topsy findings available completion of cause of
The lay	5								/ perf	ormed? 2 □ No	death?	2 □ No
of Vital F Physician: Th this certificate ral director, pag	2	Was case referred to medical examiner?	Hospital:				Othor		n (Check only			
Physical this control of 1		1 ZYes 2 No 7. Manner of Death	1 🗀 Inpatie		VOutpatient Bb. Time of	3 DO	A 4L		me 5 X Res 28d. Describe		6 ☐Other (Spec	city)
Vision of Attending Ph r death. ector: After th by the funeral fifeation.		1 ☐ Natural 5 ☐ Pending 2XXAccident investigation	found		Injury	м	3c. Injury at Work? 1 ☐ Yes			,	USE FIRE	
Division of the nation after deat Director: I in by the partition		3 Suicide 6 Could not be determined	1/11/04 28e. Place of Inju- building, etc		INK e, farm, stree	t, factory,	office			(Street a	nd Number or Ru	ral Route Number,
Division c teal or Attending P is after death. all Director: After I ed in by the funers	5	4 Notificide		ME							NE SYKESV.	ILLE,MD
			sician: To the best of iner: On the basis of	examination				e and place,	and due to the	cause(s	s) and manner as	stated.
To the Hosp within 24 hou To the Funa completely fil	2 2	9b. Signature/and title of certifier	and manner sta	ited.			License numb				ate signed (Monti	
P N O O	- 2	S. Signator Gard line of Continon	MI				O.C.M.				nuary 12	
	3	0. Name and address of person who o	ompleted cause of d	eath (Item 2)	3a) (Type, Pr	rint) .						
		5. GARON LO	KE, M	P		111	Penn	Street	, Balt	mor	e, Maryl	and 21201
State	3	1. Date filed (Month, Day, Year)	32. Registra	ar's Signatur	8 4	1	relas					
Registrar		AULT - 500	To play the		ful	100	12/					

DHMH 17 Rev 1/2001

JANUARY

GRUBBS

FLORENCE

			1 - For State Registrar	State of Maryl		artmen rtificat			and M		Reg. No.	04	00634
	Physici	20	1. Decedent's Name (First, Middle, La	ast)						2. Date of Dea	Day	Year	3. Time of Death
	/Medic		LYLE	EDGAR			ORMAN			JANUARY			1030 A M
	Examin	er	4a. Fecility Name (If not institution, gi					Location o	of Death		4c. County	of Death ARUN	IDEI
1,60			ANNE ARUNDEL M. 5. Social Security Number 6.		yrs. last birthday)	A1	NNAP(If Under:	24 Hrs.	8 Date of Birt			place (Stete or Foreign
	Funeral Director			VW., all	0 Yrs.	Months		Hours	Min.	8. Date of Birt (Month, Da 5/5/19	23 Yeer)	NOR"	TH DAKOTA
	Maryland febow	tor	10a. State 10b. County MD ANNE	ARUNDEL 10c	City, Town or Lo								10d. Inside City Limits 1 ☐ YesXX☐ No
	with the	Direc	10e. Street and Number 907 ANDREWS RO	AD		10f. Zip	Code 21060)			10g. Citizen of		ntry?
396	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Madical Extrainer mat the notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3(5) Widowed 4 □ Divorced	12. Was Decedent Ever Amed Forces? XXYes 2 No If Yes, Give Year or Dates: 195		Was Deced If Yes, spec		spanic Origin, Mexican	gin? (Spi i, Puerto	ecify Yes or No Rican, etc.)	Bla	ce - Americk, White,	
21215-0036	thin 72 hou e. an "natura Madical E	Completed	15. Decedent's 8 (Specify only highest gi		(Give	dent's Usua kind of wa DO NOT u	rk done d se retired	uring most	t of work	ing	16b. Kind of B		
2	be filed with stal Hygiene. od other than event, Inc.)	Be	10 17. Father's Name (First, Middle, Las ROGER GORMAN	t)	MAIN	TENAN	CE			e (First, Middle, M. FLE	NURSI Maiden Sumar EMING		JME ————————————————————————————————————
Maryland	2 should be f and Mental H is marked of raumatic eve	٦	19a. Informant's Name/Relationship			•		and Numbe	er or Rura	al Route Numbe	er, City or Town, MD 210		o Code)
	Pages 1 and 3 nent of Health int: if item 27 iry or other tr		BEATRICE HARTLE 20a. Method of Disposition 1 🖾 Furial 2 □ Cremation 3	20	b. Place of Disponentery, cre	osition (Nar matory or c	ne of other place	9)		Date 2004	20c. Location	City or T	
Baltimore,	permit. Page Department of Important: if any injury of once.		* 4 □Donation 5 □Other (Spec 21. Signature of Funeral Service Lice	90000		2. Name ar	nd Addres	s of Facilit	y FI	NK FUNE	ERAL HOM	IE, P	A
	402.64		23a. Part 1. Enter the disease, or conshock, or heart failure. List on	Y FINK #MO114 pplications that caused the cone cause on each line.							JRNIE, M	W 21	Approximate Interval Between Onset and Death
100	ate be executed hysician and thysician and thysician and the puriat-transit the buriat-transit the puriation and the puriation and the puriation and the puriation are the puriation and the puriation are the puriation and the puriation are the puriation and the puriation are the pur	iical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Que to (or as a cord) Due to (or as a cord) Due to (or as a cord) Due to (or as a cord)	sequence of):	bril	ve- lat	Pulm	iona	y D	iseas	2	
.o. Box 68	w requires that the death certifica been signed by the attending ph should be detached for use as th	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of print the birth 2 4 Pregnant at time 9 Unknown	Fetal death 3	⊒Ectopic p ⊒ Other <i>(sp</i>						ite of deliv	ery Day Year
rds, P.	quires that n signed b uld be deta	d by Pi	Part II. Other significant conditions	contributing to death but no	t resulting in the t	underlying o	ause give	in in Part I					he cause of death? bably 4 Unknown
Records,	e la has je 2	Completed									rmed?	death?	opsy findings available impletion of cause of
Vital	ician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?		nati'	-		26. Place	of Deat	h (Check only c	one)		
of	Phys	2	1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☐ Natural 5 ☐ Pending	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatie	of 2	28c. Injun	at			dence 6 Oth		(y)
Division	or Attending after death. Director: After in by the fune	Certification:	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be 299 Place of Injuny	At home, farm, si	M reet, factor		Yes 2		28f. Location (S City or Tox	Street and Numi wn, State)	ber or Run	al Route Number,
_	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier 1 Certifying F (Check only one) 2 Madical Ext	Physician: To the best of my aminer: On the basis of exa and manner stated.	rknowledge, dea mination and/or ii	th occurred nvestigation	at the tim	ne, date an pinion, dea	nd place, ith occur	and due to the red at the time,	cause(s) and m date and place,	anner as s and due t	stated. o the cause(s)
	To the within To the comple	Me	and an Alaskins	1/1	-	29	c. License	number 04/	,		29d. Date signe	d (Month,	Day, Year)
	61		30. Name and address of person wh 22c1 1 1 1 31. Date filed (Month, Day, Year)	o completed cause of death	(Item 23a) (Type	, Print)	7112	ip!	UD	214	10 7		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JAN 1 4 20		Signature	wii)							

State of Maryland / Department of Health and Mental Hygiene 5 Certificate of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) Year **Physician** ERI 2000 /Medical 4c. County of Deat a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner GLEN BURNIE ANNE ARUNDEL NO RTH O 8. Date of Birth (Month, Day, Year) SEPT. 16, 1934 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 9. Birthplece (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1∯M 2□F 69 MARYLAND 219-30-4747 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28e-f show event, the Medical Examiner must be notified at 1 Yes 2 No Director MARYLAND ANNE ARUNDEL PASADENA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 655 POWHATAN BEACH ROAD 21122 UNITED STATES Items 23a Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 DYes 2 No 195 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1957-Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 natural, or 1 ☐ Yes 2 No Specify: Completed by If Yes, Give Year or Dates: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) al Hygiene. ELEVATOR MECHANIC BUILDING SERVICES 18 Mother's Name /First Middle Maiden Surname 17. Father's Name (First, Middle, Last) Be if Health and Mental I THOMAS G. GOETZ ANNIE CLINE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA GOETZ - WIFE 655 POWHATAN BEACH ROAD, PASADENA, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Methad of Disposition JANUARY 15 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 Deurial 3 Removal from State 2 Cremat GLEN HAVEN MEM. PARK 2004 GLEN BURNIE, MARYLAND ° 4 □ Donation 5 Other (Specify) Furier I Service 21. Signati KIRKTEY-TUDDICK FUNERAL HOME P.A. 21061 0) CRAIN HIGHWAY S.E. GLEN BURNIE, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ~ vort resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of): attending physician P.O. Box 68760. Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown is been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 (es 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 1 ☐ Yes 2 or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one examiner? Hospital: Other: 1 ☐ Yes 2 No 1 Npatient Medical Certification: To 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient this 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation after death in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide the Hospitel within 24 hours a filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie completely 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1018 e 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 1 4 2004 Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Neme (If not institution, give street end number) 4b. City, Town, or Location of Death If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Month, Day, Home en 760men Security Number 6. Sex 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign Couptly) 1 M 2 4 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? Dull 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Merital Status Was Decedent of Hispenic Origin? (Specify Yes or No. If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2000 3 DWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) llth grade Return Clerk Sears & Roebuck 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Fuller Margaret Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Charles D. Hopkins Son 7901 Henry Ave. Apt. B, Philda., Pa. 19128 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Eden Cem. l-17-04 Collingdale, Pa. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MARCH FUNERAL HOME-EAST 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. 1101 E. North Avenue, Baltimore, MD Approximate Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) a MULTI-ORGAN FAILURE, OLD AGE, DEBILITY Due to (or es a consequence of): DIABETES MELLITUS Due to (or as a consequence of): HYPERTENSION

Physician /Medical Examiner

ettending physician end I for use as the bunal-transit

Examiner

Physician /Medical

Examiner

Directo

Funeral

ð

Completed

Be

10a. Stete

Funeral

Director

permit. Pages 1 end 2 should be filed within 72 hours efter deeth with the Meryland Depertment of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumetic event, the Medical Examinar must be notified at

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury

that initieted events resulting in death) Last	Due to (or as a consequence of	of):		
Part II. Other eignificant conditions	contributing to death but not re-	sulting in the underlyin	g ceuse given in Pert I.	23b. Did tobacco use co	ontribute to the cause of death?
				24a. Was en autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
				1 □ Yes 2 No	1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner?	Descript.			eath (Check only one)	
1 ☐ Yes 21S.No	Hospitel: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□	DOA Other: 40 Nursing	Home 5 ☐ Residence 6 ☐Ot	her (Specify)
27. Menner of Déath 1 ଔ Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occu	rred
3 ☐ Suicide 6 ☐ Could not to determined		nome, farm, street, fact	ory, office	28f. Location (Street and Num City or Town, Stete)	ber or Rural Route Number,
29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exam	nysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, death occurre ation and/or investigati	ed at the time, date and place on, in my opinion, death oc	ce, and due to the cause(s) and m curred at the time, date and place,	anner as stated. and due to the cause(s)
29h Signature And title of certifier			On License number	20d Data size	od (Manth Clay Vaca)

29c. License number

D0052861

Division of Vital Records, P.O. Box 68760,

the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours efter death. To the Funerel Director: After

completely

filled in by

29b. Signature And title of certifier

30. Name and andress of person who completed cause of deeth (Item 23e) (Type, Print)

MD 20902

SILVER SPRING 9801 ORGE AVENUE

State Registrar

			1 - For State Registrar	State of Ma	aryland		rtmen			and M		ene	04	006	37
	Physici /Medio	cal	Dependent's Name (First, Middle, Last) Out A. Fecility Name (If not institution, give si	490	162	irt	4h Cin	Tours or	Location o	of Dogsth	2. Date of Death Month January		Year 2004 nty of Death	3. Time of 12:06	Death P M
	Examir Funeral	ier	5207 Ashland Avenu 5. Social Security Number 6. Sex	.e 7. Ag	e (In yrs. las	st birthday)	If Under	Ba 1 Year	ltimr If Under:	.0 C 24 Hrs.	8. Date of Birth		N/A	lace (State o.	r Foreign
	Director		217-84-1029 1□ Usual Residence of Decedent 10a, State 10b, County	M 2XF	86	Yrs.	Months	Days	Hours	Min.	(Month, Day, Y Jan. 16,	1917	North	1 Caro 1 Caro 0d. Inside Cit	lina
	the Maryla 28a-f shor notified at	ector	Maryland N/a 100. Street and Number		Too. Oily,				more		100	Citizen	of What Coun	1 X Yes	
	h with	a Dir	5207 Ashland Avenu	e			101.21		205		1.05		S. A.	-	
920	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show diesi Extrolied from the profilled at	by Funeral Director		2. Was Decedent ! Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			Vas Deced Yes, spec	ent of His		gin? (Spe , Pu <i>e</i> rto I	cify Yes or No- Rican, etc.)		lace - Americ lack, White, city:		
21215-0036	within ane. than "	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5		16a. Deced (Give life. L	kind of wor DO NOT us	Occupa k done d e retired)	uring most	of workir	ng 16		Business/Ind	dustry	
Maryland 2	should be filed withind Mental Hygiene. I marked other ther unatic avent, It of	To Be Co	17. Father's Name (First, Middle, Last) Vaughn Zimery Rog	ers			710711		18. Mothe		(First, Middle, Ma G. Hangn	iden Sum			
re, Mar	1 and 2 s Health ar am 27 ls thar trau		19a. Informant's Name/Relationship (Type Barbara Robinson (20a. Method of Disposition	. ,	0A) !		Ishlai	nd A	venue	, Ва	l Route Number, C Ltimore, ate 20	Mary		21205	
Baltimore,	Page: nent o ant: If ury or		1 🕅 Burial 2 □ Cremation 3 □ Re `4 □ Donation 5 □ Other (Specify) 21. Signature of Furgeral Service License			eland	Mem.	Park	2 1		2004 Bo imunek F				ıd
Ba	permit. Departr Importa any Inje	[]	yan To	May	2						altimore				
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	Attons that caused a cause on each lin	ne.	9	er the mode		, such as o	cardiac o	r respiratory arresi	t,		Approximate Interval Bety Onset and D	veen Death
8760,	death certificate be executed e attending physicien and of for use as the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a											
O. Box 6	death certific e attending p ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Oolo 9 Unknown	ic. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal d	eath 3□	Ectopic pre Other (spe						Date of delive Month	<u> </u>	'ear
rds, P.	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions cont	ributing to death bu	ut not resulti	ing in the un	derlying ca	iuse give	n in Part I.		23e. Did tobad	2 No	ntribute to th 3 ☐ Proba		eath?
of Vital Records,	The ate h page	Completed									24a. Was an autopsy performe		death?	psy findings a apletion of ca	vailable use of
Vita	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?	ospital: 1 ☐ Inpatie	nt 2 🗆 🖽	P/Outpatient	3 ☐ DO	Othe	r	of Death	(Check only one)				
	ding After fune	Η,	27. Manner of eath 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	ry 2	8b. Time of Injury		Bc. Injury Work		2	8 . Describe how		th <i>er (Specify</i> urred)	
Division	i gita	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injubulg	ury - At hom c. (Specify)	e, farm, stre	et, factory,	, office		2	8f. Location (Stree City or Town, S	et and Nun State)	nber or Rural	Route Numb	er,
,	A Hospital 24 hours a Funeral (edicai	29a. Certifier Certifying Physi (Check only 2 Medical Examin-	cian: To the best of er: On the basis of and manner sta	examinatio	edge, death n and/or inv	occurred a estigation,	at the time in my opi	e, date and inion, deati	i place, a h occurre	nd due to the caused at the time, date	e(s) and no and place	nanner as sta e, and due to	ated. the cause(s)	
	To tha within 2 To tha complet	Me	29b. Signature and title of certifier	rend			29c.	License D 4	number	8	29d	Date sign	ned (Month, E	Day, Year)	
	6		30. Name and address of person who con	- 1				2 1	7 1	₩ .		110	71		
	Sta		31. Date filed (Month, Day, Year)	32. Regista	ar's Signatur		Anna		15~[Imo	1e, MD	212)6		
	Registr	ar	JAN 1 4	THU THU		10	The state of the s								

Ruby Mary Haubert 1-10-04

		1 - State Registrar	(epartment of Health and Dertificate of Death	Reg	No. 2004	
Physici /Medio Examir	cal	Decedent's Name (First, Middle, Las Anna Marie Hi An Facility Name (If not institution, give Saint Joseph	ndman street and number)	4b. City, Town, or Location of De	2. Date of Death Month JANUARY	Day Yeer	
Funeral Director		5. Social Security Number 6. Sec. 214-18-9735		Months Days Hours M	In. 8. Date of Birth (Month, Day, Young 25,	9. Birti	hptace (State or Fore untry) ryland
28a-f show	rector	10a. State 10b. County Maryland Baltimo 10e. Street and Number	10c. City, Town o	Kingsville	100	. Citizen of What Co	10d. Inside City Lim 1 ☐ Yes 2 反
23a or	ai Di	6967 Mount Visa	ta Road	21087		U.S.A.	, .
Department of Health and Mental Hygiene. Important: If item 27s or 28s-f show important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other treumstic event, the Medical Examination instituted at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes. 2 (X)No If Yes. Give Year or Dates:	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu 1 ☐ Yes 2 X No Specify:	(Specify Yes or No- lerto Rican, etc.)	14. Race - Amer Black, White Specify: Wh	
ene. than *natu ne Medical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 8th Grade	College (1-401 5+)	ecedent's Usual Occupation Give kind of work done during most of the Te. DO NOT use retired) Homemaker	working 16t	Own Home	ndustry
Mental Hygidarked other	To Be Co	17. Father's Name (First, Middle, Last) Pierno Campell		18. Mother's N	Name (First, Middle, Mail entina l		 ,-
lealth and I m 27 is me her treums		Mr. Tate J. Hindr	nan (husband) 69	Mailing Address (Street and Number or 67 Mount Vista Roo	ad, Kingsvi	lle, MD 2	1087
nt: If ite		20a. Method of Disposition 1	Removal from State cemetery,	isposition (Name of crematory or other place) of Faith Cem. 1,		c. Location - City or 1 altimono	·
Departm Importa any inju		21. Signature of Furreral Service Ligens		22. Name and Address of Facility Sc 9705 Belair Rd.,	chimunek Fui	neral Home	
nysician Medical as the parial-transit	dicai Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inditated events resulting in death) Last	a. RESPIRATORY F Due to (or as a consequence of) B. ASPIRATION PN Due to (or as a consequence of) C. SEPSIS Due to (or as a consequence of):	IEUMONIA			4 DAYS
ed by the attending ph detached for use as th	by Physician/Med	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delive Month	very Day Year
been signed beshould be dete		Part II. Other significant conditions co	ntributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did tobacc	20 use contribute to	the cause of death bably 4 DUnkno
is certificate has be director, page 2 sh	Completed				24a. Was an autopsy performed 1 Yes 2	prior to co	opsy findings available to the cause 2 No
n. After th funeral	tion: To Be	27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Inpatient 2 ☐ ER/Outpa 28a. D te of Injury (Month, Day Year) 28b. Tim Inju	tient 3 DOA Other: 4 Nursing	eath (Check only onle) Home 5 Residence 28d. Describe how in		fy)
within 24 hours after deatl To the Funerel Director: completely filled in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)		28f. Location (Street City or Town, St	and Number or Run ate)	al Route Number,
within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of my knowledge, d ner: On the basis of examination and/o and manner stated.	eath occurred at the time, date and pla r investigation, in my opinion, death oc	ce, and due to the cause curred at the time, date	e(s) and manner as s and place, and due t	stated. o the cause(s)
To the comp	Ň	29b. Signature and tile of certific	$\Lambda\Lambda$	29c. License number D 35453	29d.	Date signe (Month,	Dey, Year)
	L	30. Name and address of person who co	/ 1 / 1				

			1 - For State Registrar	State of Marylan		artment o				iene g. No. 2	004	006	39
	Physic	ian	1. Decedent's Name (First, Middle, Last)					1	2. Date of Death Month	Day	Yeer	3. Time of D	eath
	/Medi		Ruth	Harri	son				1	8	04	1:30	ΑM
	Exami	ner	4a. Fecility Name (If not institution, give s				n, or Location o		.1. 4		unty of Deeth		
-	Funeral	-	6605 Harrison 5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Ye			Date of Birth (Month, Day,		ACO 9. Birthp	lece (State or I	Foreign
	Director		219-16-6304	^{M 2} X F 91	Yrs.	Months Da	ys Hours	Min.	5-24-1	12	Bal1	timore	, Md
	pue *		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ocation					1	0d. Inside City	Limits
	Maryli f sho	ō										₩XYes 2	
	72 hours after death with the Maryland natural, or Items 23a or 28a-1 show dical Exeminant trendition at	Director	Md. AACO 10e. Street and Number	<u>_</u>	inth:	10f. Zip Cod	ie		10	g. Citizen	of What Cour		
	th with		6605 Harrison	Ave.		210	90			USA			
	ems a	Funeral	11. Marital Status	Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent		gin? (Spec	ify Yes or No- ican, etc.)		Race - Americ Black, White,		
36	s afte	by Fu	1 Never Married 2 Married	1 Tes 2 No		1 ☐ Yes 2 🟋			, , , ,		ecity: Bla		
Ş	tural'	ed b	3 Widowed 4 □ Divorced 15, Decedent's Educ	Year or Dates:	16a Dece	dent's Usual Oc	cupation	-	1		of Business/Inc		
215	within 72 ene. than "ne	plet	(Specify only highest grade Elementary/Secondary (0-12)		(Give	kind of work do DO NOT use re	one during most	t of working	7	OB. Raid O	n basiliosa in	Justiy	
21	ad with	Completed	12	College (1-401 04)	Hoi	memake	r			Hor	ne		
nd	be filed ital Hygi id other	Be	17. Father's Name (First, Middle, Last)				18. Mothe	r's Name (First, Middle, M		name)		
y la	2 should be and Mental Is marked sumatic ev	ျ	<u> </u>	rs Sr.	401 44 10			ry	Myeı				
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylar at of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23s or 28s-1 show or other traumatic event, the Medical Examiner mark by multified at	1 8	19a. Informant's Name/Relationship (Typ	·	1				Route Number. inthic	-		Code)	
	s 1 and of Health item 27 other tr	1 2	Phyllis Gaith 20a. Method of Disposition			esition (Name of matory or other		Da			on - City or To	wn, State	-
Baltimore,	permit. Pages Department of I Important: If it any injury or o	2	1 XBurial 2 ☐ Cremation 3 ☐ Re 1 Donation 5 ☐ Other (Specify)	SINUVALITUIII STATE				1-13	3-04 I	Just T	ler Va	1	
alti	permit. Departm Importa any inju		21. Signature of Funeral Service License	θ	25	Name and Ad	dress of Eacilit	v					
8	20 5 5 8	1 1	Lloyd My Este	7		LStep 1	utaw P	rs r lace	uneral ,Balti	. Ser	.,P.A. e.Md.	21217	
	Physician /Medical Examiner		23a. Par1. Enter Itld disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	or ter	.1	dying, such as	cardiac or	respiratory arre	st,		Approximate Interval Betwe Onset and De	
8760,	death certificate be executed eattending physician and dor use as the burial-transit	dical Examiner	Sequentially list conditions, if any, reading to minediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)									
.O. Box 6	y the	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Bc. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3[Ectopic pregna					Date of delive Month	ry Day Yea	ar
<u>α</u>		by Pt	Part II. Other significant conditions con	tributing to death but not resu	ulting in the u	nderlying cause	given in Part I.		23e. Did toba	acco use c	ontribute to th	e cause of dea	ith?
Vital Records,	- w 13	ed b	Drabety, Dem	entre, 15t	mon	4			1 ☐ Yes	2 DANO	3 Proba	ably 4 □Unk	known
ecc	aw as E 2 s	Completed	,	<u>'</u>					24a. Was an autopsy		b. Were autor	psy findings ava	ailable
œ.	The ate h page	E O							perform		death?	2) No	30 01
/ita	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?					of Death (Check only one				
of	shysi this c	ပ္	1 Yes 200No		ER/Outpatier	it 3 DOA		A	5 Resider)	
nc	ding F	:lon:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	\ \ \	njury at Work? I □ Yes 2 □ N		d. Describe hov	v injury occ	curred		
Division	l or Attending after death. Director: After in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify					f. Location (Stre City or Town,		mber or Rural	Route Number	r,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier 195 Certifying Phys (Check only one)	ician: To the best of my know er: On the basis of examinat and manner stated.	wledge, death ion and/or in	n occurred at the vestigation, in m	e time, date and ny opinion, deat	d place, and	d due to the cau at the time, dat	use(s) and te and plac	manner as sta e, and due to	ated. the cause(s)	
	To the within To the comple	Me	29b. Signature and title of certifier				ense number		29	d. Date sig	ned (Month, E	Day, Year)	
	11		P 4/a	MD		D -	3895	8		1/8/	2004		
	Sta	ate	30. Name and address of person who cold the state of the	npleted cause of death (Item	23a) (Type,	Print)	bytu 1	Road	#106	olle	enton	MDZ	1113

			1 - For State Registrar	State of Marylar		artment rtificate			ind M	F	Reg. No.	04	00640
	Physici /Medic	al	Decedent's Name (First, Middle, Last) RICARDO 4a. Facility Name (If not institution, give s	HOOD		4h Cilv 1	Town or	Location o	of Doath	2. Date of Dea	Day	2004	3. Time of Death
	Examir Funeral	ier	Maryland & 5. Social Security Number 6. Sex	eneral Ho. 7. Age (In yrs.		If Under Months	Bal	If Under 2	ore	8. Date of Birth (Month, Day 1/10/6			ece (State or Foreign
167	Director		216 80 4411 15 2 2 2 2 2 2 2 2 2		Yrs. ty, Town or Lo	ocation				1/10/6	58	110	MD .
	ne Maryita 8a-f sho	Director	MD. BALTO			LTIMO				·····			1 ☐ Yes 2 ☐ No
	h with th	ai DIr	10e. Street and Number 6605 KINCHELO	AVE. (APT	C)	10f. Zip	2120	7			10g. Citizen of V USA		ry?
5-0036	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or items 23e or 28e-f show event, the Medical Examinant in Italian at	by Funeral	11. Marital Status 1 ↑ Never Mamed 2 ↑ Married 3 ↑ Widowed 4 ↑ Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 20 No If Yes, Give Year or Dates:	1	Was Decedif Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto l	ocify Yes or No- Rican, etc.)	14. Rac Blac Specify	e - America ck, White, e	
21215-0	l within 72 ho iene. r than "natur the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12	cation completed) College (1-4or 5+)	(Give	dent's Usual kind of won DO NOT us FOREN	k done d e retired)	uring most	of working	ng	16b. Kind of Bu		
aryland ?		To Be C	17. Father's Name (First, Middle, Last) HOWARD	SCOTT				F	PAUL	ETTE E			
\geq	d 2 th a 7 is		19a. Informant's Name/Relationship (Type PAULETTE HOOD	oe, Print) MOTHER	19b. Mailir 6605					BALTO.	r, City or Town, MD . 2	State, Zip (21207	
altimore,	Pages 1: nent of He int: If Iten iry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ro 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Place of Dispo cemetery, cren TRO C	sition (Nam natory or ot REMAT	her place	- 1	□ /9/_	nate O4	20c. Location -		vn, Stete LE, MD.
Baltii	permit. Pages 1 an Department of Heat important: If Item 2 any injury or other once.		21. Signature of Funeral Strice License			Name S	ter es	BROS	5. F		HOME		
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or compliance, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence to (or as a consequence)	uence of): Lmm(uence of):	1 ,	te lef	n, such as o	rh	age Vir			Approximate interval Between Onset and Death
P.O. Box 68760,	at the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/Medical Ex	IF FEMALE: 23b. Wes decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Due to (or as a consequence of pregnate of the pregnant at time of depth of the pregnant at time of depth of the pregnant at time of depth of the pregnant at time of depth of the pregnant at time of depth of the pregnant at time of depth of the pregnant at time of depth of the pregnant at time of depth of the pregnant at time of depth of the pregnant at time of depth of the pregnant at time of depth of the pregnant at time of depth of the pregnant at time of depth of the pregnant at time of the pregnant a	ancy	Ectopic pre					23d. Dat Mor	e of deliver	y Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions con	tributing to death but not res	ulting in the ur	nderlying ca	iuse give	n in Part I.					cause of death?
al Records,	The la ate has page 2	Completed								24a. Was a autops perform	med?	Were autoportion to combeath?	sy findings available pletion of cause of
f Vital	Physician: rthis certificaral director, I	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital:	ER/Outpatien	t 3 🗆 DO/	A Othe			(Check only on ne 5 ☐ Reside	ence 6 Othe	er (Specify)	
Division of	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification;	27. Mannar of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	М			lo 2	8d. Describe ho	ow injury occurr	ed	
N N	itel or At irs after o rel Direct led in by		4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	y)					City or Town			
1	hekkosp n 24 hou he Fune pletely fil	Medical	29a. Certifier 1 ☑ Certifying Phys (Check only one) 2 ☐ Medical Examin	ician: To the best of my knower: On the basis of examina and manner stated	wiedge, death tion and/or inv	n occurred a vestigation,	it the time in my op	e, date and inion, deatl	i place, a h occurre	nd due to the cand at the time, d	ause(s) and ma ate and place, a	nner as ste	ted. he cause(s)
	Tot withi	M	29b. Signature and title of certifier	in young	/ M		License	number +78		2	9d. Date signed	(Month, D.	ay, Year)
(Sonial Yousu	poleted cause of death (Item	m 23a) (Type.	1	nd	C	beni	eral	Hosp	ital	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture								

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

4

JAN 1

parker

32. Registrar's Signature

			1- For State of Maryland / Department of Health and Me Certificate of Death		iene g. No. 2004	00642
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Eddi E Lee HARRIS	2. Date of Death Month	Day Year 12 2004	3. Time of Death
*	Examin Funeral Director		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death ADDITION ADDITION 5. Social Security Number 6. Sex 1 Months 6. Sex 7. Age (In yrs. last birthday) When the property of the propert	8. Date of Birth (Month, Day, 1/15/19		ace (State or Foreign ry) ABAMA
	72 hours atter death with the Maryland natural; or litems 23a or 28e-f show itsal Examiner must be notified at	Director	10a. State 10b. County 10c. City, Town or Location AL JEFFERSON BIRMINGHAM			d. Inside City Limits XX Yes 2 □ No
	eath with the		10e. Street and Number 10f. Zip Code 1355 MOHICAN DRIVE 35214 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specific Actions)		USA 14. Race - America	
920	ours atter de ral', or item Examinari	by Funeral	11. Marital Status 1 □ Never Married	Rican, etc.)	Black, White, e	tc.
Maryland 21215-0036	d within piene. r than the Mex	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) NURSING	ng	16b. Kind of Business/Ind HOSPITAL	ustry
yland;	should be filed ind Mental Hygis marked other umatic event, III	To Be C	17. Father's Name (First, Middle, Last) UNKNOWN 18. Mother's Name HANNA	AH HARPE	faiden Sumame) R	
more,	es 1 and 2 of Health a f item 27 lg		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural 1048 APPLE STREET, BIR 20a. Method of Disposition 1X Surial 2 □ Cremation 3 ■ Nemoval from State 1048 APPLE STREET, BIR 20b. Place of Disposition (Name of cemetery, crematory or other place) 14 □ Donation 5 □ Other (Specify) ELMWOOD CEMETERY	RMINGHAM ate 2		vn, State
Balti	permit. Pag Department Importent: I any injury o		21. Signation Funeral Service Leans e 22. Name and Address of Facility FIN 426 CRAIN HWY., S, G	K FUNER GLEN BUR	AL HOME, PA NIE, MD 210	
	/Medical Examiner the private the private the private the private the private the private the private that the private the private that the pr	dical Examiner	23a. Part I Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	hyth + Di		Approximate Interval Between Onset and Death
P.O. Box 68	death certiti e attending od tor use as	Physiclan/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of deliver Month	y Day Year
	sign d be	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute to the	N/
al Reco	The ate h page	Completed			ed? prior to com death? 1 Yes 2	
Division of Vital Records,	To the Hospitel or Attending Physicien: within 24 hours stee deals. To the Funerel Director: After this certific completely filled in by the funeral director,	Certification; To Be	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No	ne 5 🗌 Resider 8d. Describe hov	nce 6 Other (Specify) w injury occurred	DAPOLIS
	e Hospitel of 24 hours at 8 Funerel D eteky filled in	edical Cer	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and manner stated. Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	nd due to the car d at the time, dat	use(s) and manner as sta te and place, and due to t	ted. he cause(s)
	To the H within 24 To the Fl	Me	29b. Signature and title of certifier Alillian Paper Deputy 29c. License number Deputy 29c. Lice	4 29	d. Date signed (Month, D	ay, Year)
_	φ			erica	CA. 21	035
	Sta Registr		31. Date filed (Month, 124 1 2004 32. Registrar's Signature			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JANUARY 12, 2004 KATHY ALINE HEMSTETTER 7:00 A M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 319 NAJOLES ROAD MILLERSVILLE ANNE ARUNDEL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (Sta Months | Days | Hours | Min. | UNE 27, 1953 | WISCONSIN 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 1 F 264-08-1497 50 Yrs. Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MARYLAND ANNE ARUNDEL MILLERSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 319 NAJOLES ROAD 21108 Itеms 23a UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced Specify. WHITE natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame Be ARTHUR JACK BROMLEY SHIRLEY ANN SCHEIMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is eny injury or other tra THOMAS HEMSTETTER JR. - HUSBAND 319 NAJOLES ROAD MILLERSVILLE, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State JANUARY 15, 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State 2004 CATONSVILLE, MARYLAND ^4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY Funeral Service Cicensee 21. Signature KIRRLEY TOO TOOK FUNERAL HOME P.A. CRAIN HIGHWAY S.E. GLEN BURNIE, MARYLAND 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Sdevotic Immediate Cause (Final disease or condition resulting in death) Erdio Vesculzi oinst VISEZ SE **Physician** /Medical Due to (or as a consequence of) Examiner se Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to dor as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760 Completed by Physician/Medical attending for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐ Pregnant at time of death Day 5 Other (specify) the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Pes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s has autopsy performed? Division of Vital director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 PH sidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural
2 Accident 5 Pending death. М 1 ☐ Yes 2 ☐ No investigation within 24 hours after deati To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Destifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifiel (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7845 OAKWOOD ROAD SUITE 101 LUIS R. FLORES GLEN BURNIE, MARYLAND 21061 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

			State of Maryland / Department of Health and Mental Hygiene 2 0 0 4 0 0 5 4											
Discoult Com-			Decedent's Name (First, Middle, Last)								2. Date of Do	eath Day	Year	3. Time of Death
	Physicia /Medic		MILDRED A. HANNAH								JAN	11	2009	
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea										AC County of Death ANNE ARUNXE	
			NORTH ARUNDEL HUSPITAL GLUNDS. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year						If Under 24 Hrs. 8. Date Mor. DEC.		116	inh	2 14 10 0	
	Funeral Director		5. Social Security Number 6. 216-16-3595	Sex 7 1□M 2 ^M F	7. Age (In yrs. II 79	ast birthday) Yrs.		Days	Hours	Min.	(Month, D	AY, Year)	9. BIN	hplace (State or Forei untry) RYLAND
			Usual Residence of Decedent		, ,						DEG. 2			
	land		10a. State 10b. County		10c. City	, Town or Lo	ocation							10d. Inside City Limi
	Mary fied	to	MARYLAND ANNE ARUNDEL GLEN BURNIE										1 ☐ Yes 2 🖺 N	
	r 28a	Director	10e. Street and Number 10f. Zip Code									10g. Citizen of What Country?		
	within 72 hours after death with the Maryland ene. than "naturel", or Hems 23e or 28e-f show the Madical Exemirer must be notified at	ai D	1595 ANNAPOLIS DRIVE				21060					UNITE	ED STAT	ES
920		by Funerai	11. Marital Status 1 Never Married 2 Married 2 Widowed 4 Divorced	12. Was Deced Armed Ford 1 Yes 2 If Yes, Give Year or Dat	es? Mo		Was Deced If Yes, spec	ify Cuba	ispanic Ori n, Mexicar Specify:	gin? (Spen, Puerto	ecify Yes or N Rican, etc.)		4. Race - Ame Black, Whit Specify: W	
200	72 ho	ted	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of workin							ina	16b. Kin	d of Business	Industry	
HANNAH, MILDRED Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other treumetic event, it a Madical Examinal must be notified at once.	pie	Elementary/Secondary (0-12) College (1-4or 5+) ELECTRONICS WORKER							9		MANUFACTURING		
		Completed	11			ELEC	TRONI	CS W						TURING
		To Be	 Father's Name (First, Middle, Las EDWARD BRANNOCK 	t)							SOMMER		Sumame)	
			19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address	(Street a	and Numbe	er or Rur	al Route Numi	ber, City or	Town, State,	Zip Code)
			TWYLA MILLER - DA	AUGHTER		1006	7th	AVEN	IUE (GLEN	BURNIE	E, MAF	RYLAND	21060
			20a. Method of Disposition			lace of Dispo	osition (Nam	ne of ther plac	9)	JANU	15 THY 15	20c. Loc	ation - City or	Town, State
			1 ☑ Burial 2 ☐ Cremation 3 '4 ☐ Donation 5 ☐ Other (Spec			AR ĤIL				004		BROOK	CLYN PA	RK, MARYLA
HA Balti			21. Signature of Funeral Service	ensee							NERAL H			61 MARYLAND
Division of Vital Records, P.O. Box 68760,	Physician /Medical Examiner		shock or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death			
	Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	ed by Physician/Medicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ی د	Arcolor as a consequence of the	dens (2	ARC	OI D	U	TRIA	JE CA	101 To (45==0.00)
			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		nth 2 ∏Fetal ant at time of de	death 3[□Ectopic pre					2	3d. Date of de Month	livery Day Year
			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown			
		Completed									24a. Wha auto peri 1 ☐ Yes	opsy formed?	prior to death?	utopsy findings availat completion of cause o
		Be (25. Was case referred to medical examiner?							of Deat	h (Check only	one)		
	Phyeic this co	2	1 ☐ Yes 2 Ø No			ER/Outpatie	The second second	_	4 🗆 140	-	me 5 Res			cify)
	ding Pl h. After tl funera		27. Manner of Death 1. Natural 5 ☐ Pending 2 ☐ Accident investigati		28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? M 1 □ Yes 2 □ No						28d. Describe how injury occurred			
Divisi	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification;	3 Suicide 6 Could not determine	be 28e. Place	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
*	the Hospitel hin 24 hours a the Funeral I npletely filled	ledical (29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one) Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	To th withir To th	×	29b. Signature and title of certifier 29c. License number									29d. Date signed (Month, Day, Year)		
			Ehrendy	thin It	ouce i	office	R.	DO	059	18	5	JANE	JARY	11,2004
	10		30. Name and address of person who		of death (Item		Print)]	DRIV	G ,	GLEN	Bu	RNIE	, m) 210
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature											
	Registr		JON 1 4 20		uns B	620	and the							

			1 - For State Registrar	State of		d / Depa		of H	ealth a	and M	lental Hy		•	00645
			1. Decedent's Name (First, Middle, La	st)					_		2. Date of De	ath Day	Vasa	3. Time of Death
	Physici /Medio		Cornelia Esther H	arper							1	13	2004	10:20 A M
	Examir	ier	4a. Facility Name (If not institution, give		oer)		4b. City, To	own, or	Location of	of Death			County of Deeth	
			13801 York Road 5. Social Security Number 6. S		Age (in yrs.	last histhday	Cock		ville		O Data of Bir		altimore	
**)	Funeral Director			M 2∏F /	92	Yrs.		Days	Hours	Min.	8. Date of Big (Month, Da May 6,	rn ry, Year) 1011		plece (State or Foreign intry)
			Usuel Residence of Decedent								rady 0,	171.	Conne	ecticut
	anylan show	3	10a. State 10b. County			y, Town or Lo								10d. Inside City Limits
	8a-1	Directo	Maryland Baltim	ore	С	ockeys								1 ☐ Yes 2 ☐ No
	ath with the Marylar 23a or 28a-f ehow wat be notified at		10e. Street and Number	# 11000			10f. Zip C					_	en of What Cou	·
	leath	eral	13801 York Road	HZ3Z 12. Was Decede	ent Ever in U.	S. 13. V		LO30		gin? (Sp			ed State	
Ω	ifter dea or Items	Fun	1 ☐ Never Married 2 ☐ Married	Armed Force 1 ☐ Yes 2: If Yes, Give:	es?					, Puerto	ecify Yes or No Rican, etc.)		Black, White,	
ğ	172 hours after death with the Maryland *natural', or Items 23a or 28a-f show idical Examinat her notified at	d by	3√ Widowed 4 Divorced	If Yes, Give Year or Date	9S:		1 □ Yes 2 X	ĽI No	Specify:				Specify:	White
21215-0036	be filed within 72 ho tal Hygiene d other then "natur event, the Medical	Completed by Funeral	15. Decedent's Ec (Specify only highest gra	lucation de co <i>mpleted)</i>		16a. Deced	tent's Usual kind of work DO NOT use	Occupa done di	tion uring most	t of work	ing	16b. Kin	d of Business/Ir	ndustry
12	within 72 ene. then 'na'	d E	Elementary/Secondary (0-12)	College (1-4	or 5+)		memake					0.	vn Home	
	Hygid Other ent, I	Be Co	17. Father's Name (First, Middle, Last)			110	memare		18. Mothe	r's Name	(First, Middle			
Maryland		To B	George H	olmes		Edwar	ds		Co	rne	lia		(Clark
a	s 1 and 2 should f Health and Mer Item 27 le marke othar traumatic	-	19a. Informant's Name/Relationship (19b. Mailir	g Address (Street a	nd Numbe	r or Rura	il Route Numb	er, City or	Town, State, Zi	p Code)
	and ealth m 27 nar tr		Mr. Paul E. Harp	er (son)	1						ium, Ma			
altimore,	0 0		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from St	ale	lace of Dispo emetery, cren			<i>)</i> J	Jan.	14,	20c. Loc	ation - City or T	own, State
Ħπ	permit. Pag Department Importent: I any injury c		* 4 □ Donation 5 □ Other (Specify			view C			1	2004		Balti	more, N	aryland
Ba	perm Depa Impo any i		21. Signature of Funeral Service Licer	0	Brian									alley, P.A.
8	4		23a Part1. Enter the disease, or com- shock, or heart failure. List only	olications that cau	sed the death								MD 21	Approximate Interval Between
	Priysician /Medical Examiner	er	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause letter those by a	a. Due to (or	as a consequ	LAT.	DE	and the second						Onset and Death
	uted d ansit	Examiner	Cause (Disease or injury that initiated events											
o Î	ate be executed nysician and he burial-transit		resulting in death) Last	Oue to (or	as a consequ	ence of):								
3760	ate be hysicia he bu	ical		. d										
X 68	entifica ling pl	Med	IF FEMALE:											
P.O. Box	The taw requires that the death certificat tie has been signed by the attending phy age 2 should be detached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		n 2 ∏Fetal it at time of de	death 3	Ectopic preg Other <i>(spec</i>					23	3d. Date of delive Month	ery Day Year
_	res that igned b	by P	Part II. Other significant conditions of	ontributing to deat	th but not resu	ulting in the ur	nderlying cau	ise give	n in Part I.		23e. Did t	obacco us	e contribute to t	he cause of death?
ord	w require been si should b	ted	CORONARY A	RTERY)15EA	SE				10'	∕es 2⊡	HNo 3 □ Prot	oably 4 □Unknown
Vital Hecords,	e taw r has be	Completed	PERIPHERAL	ARTE	RIAL	DIS	EASE	=			24a. Was autop	sy	prior to co	opsy findings available impletion of cause of
E E		Con									perfo 1 ☐ Yes	rmed? 2 No	death? 1 ☐ Yes	2□ No
<u> </u>	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:				Other			Check on c			
ō	Phy this ral d	: To	1 ☐ Yes 2 ☑ No 27. Manny of Death	1 ☐ Inp		ER/Outpatien 28b. Time of		c. Injury	4 PNU		ne 5 Residente 128d. Describe 1		Other (Specif	(y)
0	Attending Physic death. ector: After this obttoe the funeral director.	tion	1 Matural 5 Pending 2 Accident investigation	(Month,	Day Year)	Injury	м	Work?	?" es 2∐1		.50. 5030.150	iow injury	00001160	
Division	Attendi	ifica	3 Suicide 6 Could not be determined	28e. Place of	Injury - At ho	me, farm, stre	et, factory, o	office		- 1	28f. Location (S	Street and	Number or Rura	al Route Number,
5	tal or rs afte al Dir ed in	Certification:	T I TOMICO	building	, etc. (Specify	,					City or Tov	vn, State)		
	To the Hospital or Attence within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the be niner: On the basi and manner	is of examinat	wledge, death ion and/or inv	occurred at restigation, in	the time n my opi	e, date and inion, deat	d place, a h occurre	ed at the time,	date and p	place, and due to	the cause(s)
	To To	2	29b. Signature and title of certifier	Car	all,	mo	1	-	number	92		29d. Date	signed (<i>Month</i> ,	Day, Year)
	D		30. Name and address of person who	completed cause	of death (Item	- //	252.1	10	ハロレ	P	D - C/	100	111	ve Shirt
	Sta	te.	31. Date filed (Month, Day, Year)	32. Rea	istrar's Signat	ture	5801	1	UKK	, 10	D. a	5054	1301	SE J. Han
	Registr		JAN 1 4 200		ويمع		Som.	2000						
DF0	MH 17 HeV 1/2	UÜT		*		1 3	State State of	0.0.1						

DHMH 17 Hev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 00646 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 548 PM **Physician** 2004 ALEVTINA WASYSZYN JAN 09 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Min. Jan. 5, 1 HOWARD GENERAL HUSPITAL HOWARD TOUNTY Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 83 1 M ACK 090-38-4628 Yrs. Russia Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a, State 10b County items 23a or 28e-f show the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Hanover Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21076 United States 1476 Gesna Drive Funeral death 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) Black, White, etc. 1 and 2 should be filed within 72 hours after 1 □ Never Married 2 □ Married White Maryland 21215-0036 1 ☐ Yes 2 🛛 No "naturs!, or If Yes, Give Year or Dates: Completed by 3 ™ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Medicine Registered Nurse . Pages 1 and 2 should be filed w trent of Health and Mental Hygie tent: If item 27 is marked other t jury or other traumatic event, in 18. Mother's Name (First, Middle, Maiden Sumame) unk. 17. Father's Name (First, Middle, Last) Basil Sabinin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Hanover, Maryland 21076 Irene Andreadis - Daughter 1476 Gesna Drive Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or Meadowridge Mem. Pk. 1/13/04 Elkridge, Maryland * 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Gary L. Kaufman Funeral Home At MMP., Inc. 7250 Washington Blvd. Elkridge, Maryland 21075 UMON Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final HOURS SEPTIC **Physician** SHOCK resulting in death) /Medical Due to (or as a consequence of) Examiner HOURS BACTEREMIA GRAMI NEGATIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in ritiated events resulting in death) Last Due to (or as a consequence of) Examiner PNEUMONIA DAYS burial-tran Due to (or as a consequence of) Box 68760 VAYS URINARY INFECTION TRACT Physician/Medical the use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day ō 5 Other (specify) P.O. I detached 9□ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 Yes 2 No 3 Probably 4 → Thknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s 2 1 No 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 1 ☐ Yes 2 ☐ No 1 Impatient 2 ER/Outpatient 70 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Hospital or Attending Pl 24 hours after death. Funerel Diractor: After the Certification: Injury 1 ANatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide To the Hospital of within 24 hours all To the Funerel D Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier D42892 Burdian 09 2004 COLVMBIA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PARKWAY MP 21044 10724 LITTLE PATUXENT CHUIDIAN FRANCIS 22. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

		-	For State Registrar	State of Marylan	nd / Depa <i>Cer</i> n	rtment of H tificate of I	lealth and Me Death		ene 2004	00647			
	6	_	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death			
	Physicia /Medic	al -	Wilbert	Leroy	Jones			1 8		5:43a ^M			
	Examin	er	4a. Facility Name (If not institution, give s				Location of Death		4c. County of Deat	n III			
			5908 The Alameda 5. Social Security Number 6. Sex		last birthday)	If Under 1 Year		8. Date of Birth		hplece (State or Foreign untry)			
100	Funeral Director		227-44-2516	M 2□F 68	Yrs.	Months Days	Hours Min.	(Month, Day, 1–14–35		uintry)			
	D		Usuel Residence of Decedent							40d tasida Cita Limita			
	ahow	_	10a. State 10b. County	10c. Ci	ty, Town or Loc					10d. Inside City Limits M☐ Yes 2 ☐ No			
	8a-f s	Director	Md. NA		Baltin			10	g. Citizen of What Co				
	with ti	ă	10e. Street and Number			10f. Zip Code 21239	.	,,	USA	and i			
	eath	Funerai	5908 The Alameda 11. Marital Status	12. Was Decedent Ever in U	I.S. 13. V	Vas Decedent of H	ispanic Origin? (Spec	ify Yes or No-	14. Race - Ame				
36	should be filed within 72 hours after death with the Maryland and Mental Hygiene. marked other than 'ratural', or Itams 23a or 28a-f show imaric event, it a Madigal Examinar must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:	11	Yes, specify Cuba	an, Mexican, Puerto R Specify:	ican, etc.)	Black, White	e, etc. Black			
Ö	72 hou	Completed	15. Decedent's Educ (Specify only highest grade		16a. Deced	ent's Usual Occup	ation during most of working	g 1	6b. Kind of Business/	Industry			
21	ithin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	OO NOT use retired	1)						
2	filed w Hygier Sther th		10th grade 17. Father's Name (First, Middle, Last)		Ord	erly Tech	18. Mother's Name		Johns Hopk faiden Sumame)	ins Hosp.			
Maryland 21215-0036	id be figured by the figure of	To Be	James	Jo	ones		Ann		Tucker				
ary	shou ind M mar umat	-	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailin	g Address (Street	and Number or Rural	Route Number,	City or Town, State, 2	Zip Code)			
Σ	and 2		Nannie B. Jones	Wife		THE .	St., Balti						
ore	of He of He fitem roth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R		Place of Dispos cemetery, crem	sition (Name of natory or other place		ate 2	20c. Location - City or	Town, State			
Ĕ	Pag ment tant: I		* 4 ☐ Donation 5 ☐ Other (Specify)	Gi		nt Cem.	1-13-						
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic a once.		21. Signature of Funeral Service License	Herry	> Ma	Name and Addre	East 1	101 E. N	North Ave.	21202			
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caused the dea ne cause on each line.	th. Do not ente	er the mode of dyin	ng, such as cardiac or	respiratory arre	st,	Approximate Interval Between Onset and Death			
A	Physician		Immediate Cause (Final disease or condition resulting in death)	Carcino		of Li	ing		3 years				
1	/Medical Examiner		resulting in dealin)	Due to (or as a consec	quence of):		2		Olisot and Boath				
	. 18.1. 18 .0	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec	quence of):								
	uted 1 ansit	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events										
oʻ	exection and and rial-tra		resulting in death) Last	Due to (or as a consec	quence of):								
8760,	cate be executed physician and the burial-transit	dicai	C.	d									
9	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Med	IF FEMALE:	20-16									
Box	eath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of	al death 3	Ectopic pregnancy Other (specify)	/		23d. Date of del Month	Day Year			
o.	at the de by the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	dealli 5	Cities (specify)							
Δ.	that the the the the the the the the the th		Part II. Other significant conditions con	ntributing to death but not re	sulting in the ur	nderlying cause giv	ren in Part I.	23e. Did tob	acco use contribute to	the cause of death?			
rds	quires n sign ald be	ed by		· · · · · · · · · · · · · · · · · · ·				1 X Ye	s 2 No 3 P	robably 4 Unknown			
Vital Records,	law requir as been si 2 should	Completed						24a. Was ar autops		utopsy findings available completion of cause of			
Re	The la	mo						perform					
ita	ysician: The is certificate his director, page	BeC	25. Was case referred to medical examiner?				26. Place of Death	(Check only one	9)				
More		2	1 ☐ Yes 2 ☐ No		ER/Outpatien		4 Ruising Hon		nce 6 Other (Spe	cify)			
o uc	ling P. After t funera	ino.	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo	rk? Yes 2 □ No	8a. Describe no	w injury occurred				
Division	death death ctor: y the t	licat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At I	home, farm, str				reet and Number or Ri	ural Route Number,			
Ω̈́	after Dire	Certification:	4 Homicide	building, etc. (Spec	ufy)			City or Town	, State)				
/	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th compietely filled in by the funeral	edical (sician: To the best of my kn iner: On the basis of examin and manner stated.									
	To th within To th compl	Me	29b. Signature and title of certifier	.0 0		29c. Licens	se number		d. Date signed (Mont				
	5		> Clearles Gall	ttw)>		N.S.	>546	\(I	an 12, 2				
	X		30. Name and address of parson who co	ompleted cause of death (He	om 23a) (Type,	Print) Raven	Blue, I	Saffino	te, MD 2	(239			
1	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Star 1 4 2004		1/2 Soul	8.		,	·			

DHMH 17 Rev 1/2001

ORIGINAL

				State of State Amend Item#18perFHG827 1/1	Maryland 6/04 EW	d / Departm Certific	nent of F	lealth and Death	Mental H	ygiene	004	00648
				Decedent's Name (First, Middle, Last)	-				2. Date of D			3. Time of Death
		Physicia /Medic		William Edward Kudrick					Jan	Day	2004	8:25 a M
		Examin	er	4a. Facility Name (If not institution, give street and numb	ai fen	ter 8	City, Town, o	r Location of Dea	th	4c. Co	ounty of Death	nic .
		Funeral			. Age (In yrs. Ia	ast birthday) If U Yrs. Mon	Inder 1 Year oths Days	If Under 24 Hrs Hours Min	(Month, E	lav Year)	9. Birth	place (State or Foreign
		Director		Usual Residence of Decedent					Nov. 5	, 1939	Penn	sýlvania
	Marylar	r 28a-f ehow	ō	10a. State 10b. County Maryland Baltimore	10c. City,	Town or Location, Balti						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	death with the Maryland	or 28a- e notif)irect	10e. Street and Number			f. Zip Code		<u></u>	10g. Citizer	n of What Cou	
	ž.	23a	a	4 Farwell Court				21236		и	.s.A.	
		ar, or items	by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Deced Ammed Forc	ent Ever in U.S es? DNo Victue es: Era	3. Was D If Yes, am 1 □ Ye	ecedent of H specify Cuba es 2 🗓 No	lispanic Origin? (s an, Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)		Race - Americ Black, White, pecify: W	
	15-06	"nature		15. Decedent's Education (Specify only highest grade completed)	Ела		Usual Occup	ation during most of wo	nking	16b. Kind	of Business/In	dustry
2	2127 d withir	l Hygiene. other than rent, Ire M	Completed	Elementary/Secondary (0-12) College (1-4	or 5+)	Claims i		•		Socia	l Secw	rity Adm.
	ם 🖁		3e C	17. Father's Name (First, Middle, Last)					me (First, Middl			
5	Val	and Mental is marked o aumatic eve	To Be	Joseph Kudrick					Zoku			
adrick, William	altimore, Maryland 21215-0036	Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic evense.		19a. Informant's Name/Relationship (Type, Print) Mrs. Mary Kudrick (Wif	(e)			and Number or R , Baltim			own, State, Zip	Code)
7	s tar	item othe		20a. Method of Disposition	20b. Pla	ace of Disposition metery, crematory			Date		ion - City or To	own, State
7	im Page	ant: If ury or		1		rney Vall	Ley Mer	n'l 1/1.	4/2004	Timon	ium, Ma	ryland
77	Balti permit.	Departi Import any inj once.		21. Signature of Funeral Service Licensee	1			ss of FacilitySci				
7		70		23a. Part1. Enter the disease, or complications that cau	sed the death.						21236	Approximate
	Ph	nysician		shock, or heart failure. List only one cause on each immediate Cause (Final disease or condition	h line.							Interval Between Onset and Death
	1	Medical xaminer		resulting in death)	as a conseque	ence of):						years.
			ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	as a conseque	ance of):						
	xecuted	sician and burial-transit	Examiner		as a conseque	ence of):						
	68760, tificate be ex	iysician ne buria	icalE	d								
	r 68			IF FEMALE:								
	I Records, P.O. Box 68760, The law requires that the death certificate be executed	ned by the attending plot detached for use as t	Physician/Med	23b. Was decedent pregnant in the past 12 months?	h 2 ⊡ Fetalo ntattime of dea	death 3□Ectop	ic pregnancy r (s <i>pecify)</i>			23d	. Date of delive Month	ery Day Year
	IS, P.	500	þ	Part II. Other significant conditions contributing to deal	h but not result	ting in the underlyi	ng cause give	en in Part I.				ne cause of death?
	Orc	peen	eted							Yes 2□N		
	Rec The lav	has je 2	Completed								4b. Were auto prior to cor death? 1 ☐ Yes	psy findings available mpletion of cause of
	ital	certificate rector, pag	Bec	25. Was case referred to medical examiner?				26. Place of De	ath (Check only		12.10	
	y V	his ce Il dire	2	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inp		R/Outpatient 3		4 Nursing F	lome 5 ☐ Res	idence 6 🗆	Other (Specify	γ)
	On C	th. : After t s funera	tlon:	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	njury Day Year)	28b. Time of Injury M	28c. Injun Work	/at <br Yes 2 ∐No	28d. Describe	how injury or	curred	
	Division of Vital Records, to Attending Physician: The law requires I	within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director; to make the funeral director.	Certification:	3 Suicide 6 Could not be 28e. Place of	Injury - At hom, etc. (Specify)	ne, farm, street, fac	ctory, office			(Street and N wn, State)	umber or Rura	l Route Number,
6	Hospita	24 hours Funeral stely filled	Medicai C	29a. Certifier (Check only one) 2 Medical Exeminer: On the basi and mannel	is of examination	rledge, death occur on and/or investiga	red at the timation, in my of	ne, date and place pinion, death occu	e, and due to the arred at the time	cause(s) and date and pla	i manner as st ce, and due to	ated. the cause(s)
	To the	within To the	Me	29b. Signature and litle of certilier		The state of the s	29c. License	number		29d. Date si	gned (Month,	Day, Year)
		X		Moderatak	3	up	D	0054440		witness data	11/04	
		10,		30. Name and address of person who completed cause Dr. A. KOKOTOKIS 9100	of death (Item 2	23a) (Type, Print)	re Dr	ive Bal	hmor.	Md.	213	137
		Star Registra		31. Date filed (Month, Day, Year) 32. Reg	istrar' Signatu		South.)				-

State of Maryland / Department of Health and Mental Hygiene ? [] [] [] For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) January 10, 2004 **Physician** 10:40A M Kimberlin Charles Bobby /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick Frederick Memorial Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | Min. | May 3, 1943 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign 5. Social Security Number **Funeral** 1**X**⊃M 2□ F Virginia 218-38-6617 60 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural" or harmonia. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 1 Yes 2 No Frederick Frederick Maryland Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21702 U.S.A. 7934 Yellow Springs Road Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 No Year or Dates 1964-1968 Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Oil Burner Technician Oil Company 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Kimberlin LuAnn Singleton Wess Jacob ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7934 Yellow Springs Road, Frederick, Md. 21702 Susan P. Kimberlin Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1X Burial 2 Cremation 3 Removal from State Cedar Lawn Memorial PK. 01-13-04 | Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Ändrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, 21. Signature of Funeral Service Licens K. hoel Bra Md. 21740 23a. Pert1. Enter the disease, or complication, hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final month **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Completed by Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Year in the past 12 months? Month Day detached for 5 Other (specify) ☐Yes 2☐No 9 Unknown á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed should be 3 Probably 4 Unknown 1 Yes 2 🗀 No peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death To the Hospital or Attending 5 ☐ Pending 1 X Natural 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours after deatl To the Funerel Director: 6 Could not be determined 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 111/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FREDERILK 204

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

GC



ORIGINAL

TANEY

AVE

State of Maryland / Department of Health and Mental Hygiene? [] [] [] 00650 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician 3:00 AM January 2004 Pancer Kennv /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolitan Assisted Living Facility Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, 4/17/21 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 200 Director 213-40-9339 82 Fiume, Italy Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Medical Exeminer must be notified at 1 ☐ Yes 2√CtNo Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with 710 Americana Drive Apartment B 21403 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes **XX**No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: þ 3 📆 ₩idowed 4 🗆 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Home Maker Own Home other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Department of Health and Mental Important: If item 27 is marked o eny injury or other traumatic eve once. Pages 1 and 2 should be 0svaldo Pancer Fanny Zarwanitzer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Abraham Avidor/son 1101 New Hampshire Ave NW, Washington, DC 20037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Kneseth Israel Cem 1/11/04 Annapolis, Maryland permit. 21. Signature of Funeral Service License 22. Name and Address of Facility 12 Ridgely Avenue Annapolis, Maryland 21401 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, cevebuo vascular disease Immediate Cause (Final disease or condition resulting in death) Physician 16av /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): physician a the burial-1 Records, P.O. Box 68760 Physician/Medical as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown Day Month Year 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ heavt tailure 1 🗌 Yes 2 No 3 Probably 4 Unknown been si Completed Chronic 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has I certificate 1 ☐ Yes 2/2 No Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 4 Shursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: ٩ 1 ☐ Yes 2 ☑ No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: / 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗀 Homicide within 24 hours after To the Funeral Dire 150 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number Bertgate Rd. Anvapolis, Und 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) elonicu, mo 32 Registrar's Signature 31. Date filed (Month, Day, Year) JAN 1 4 State 4 2004 Registrar

			1 _ State	State of Marylan		artment of H			giene ,	2004	004	551
			Registrar 1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath		3. Time of	Death
м	Physici		Benjamin F. La	ano				January	Day v 11	2004	9:20	ΛМ
	/Medic Examin		4a. Fecility Name (If not institution, give s			4b. City, Town, or	Location of De			ounty of Death		
	LAGITIII	e.	Gilchrist Cent	ter		To	wson			Baltin	ore	
roj,	Funeral		Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 H Hours Mi		th v. Year)		place (State o	r Foreign
E	Director		244-09-7212	M 2□F 82	Yrs.	Working Days	1.00.0	Sept. 8	8 , 19	21 Nort	h Caro	lina
	pg &		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Lo	ocation					10d. Inside Ci	tv Limits
	Aaryla sho	ō									1 🗌 Yes	•
	28a-1	ect	Md. Baltin	nore	Fr	eeland 10f. Zip Code	<u> </u>		10a. Citize	on of What Cou	intry?	
	with or	Funeral Director	1317 Walker Road	4		210	153			USA	,	
	na 23	era		2. Was Decedent Ever in U	I.S. 13.	Was Decedent of H		(Specify Yes or No	- 14	. Race - Ameri		
S	r Iter		1 ☐ Never Married 3€ Married	Armed Forces? 1XXYes 2 □ No If Yes, Give				erto Hican, etc.)		Black, White	, etc.	
ဇ္ထ	ral', o	by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates: WWI	I	1 ☐ Yes 2√☐ No	Specify:		5	pecify:	lhite	
5-0	72 honatu	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occupa	during most of v	vorking	16b. Kind	d of Business/Ir	ndustry	
7	Athin ne han	ldm	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired	,					
2	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Itema 23e or 28e-f show event, the Madiral Examinar must be notified at		17. Father's Name (First, Middle, Last)	3	Senio	r Designe		lame (First, Middle,		anical	Engine	ering
anc	ntal hed of	Be	Oscar Julius	lane			Della			omamo,		
Maryland 21215-0036	should ind Men inarke umaric	ဥ	19a. Informant's Name/Relationship (Typ		19b. Maili	na Address (Street)			er. City or	Town. State. Zi	p Code)	
<u>≅</u>	ad 2 s th ar th ar 27 ls trau		Mrs. Helen May Lane		Various and	Walker Bo	and the second	0.0000000000000000000000000000000000000				
altimore,	nit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan ortainent of Heath and Mental Hygiene. ortainent of Heath and Mental Hygiene. ortainert if Item 27 is marked other than "natural", or Itema 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at a.		20a. Method of Disposition	20b. I	Place of Dispe	osition (Name of matory or other place		Date Date				
Ë	Peges nent of int: If It iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	•	ervice Co	1	.3/04	Tows	on. Mar	vland	
alti	permit. Peges Department of Important: If I any injury or once.		21. Signature of Funeral Service License			2. Name and Addres				_		Inc.
m	Depa Impo eny ii		muchael	1 Russ	1	050 York						
			23a. Part1. Enter the disease, or complex shock, or heart failure. List only on	ations that caused the dear	th. Do not en	ter the mode of dyin	g, such as card	iac or respiratory ar	rrest,		Interval Bet	ween
	Physician		Immediate Cause (Final disease or condition a Malignant melanoma Je									
	/Medical		resulting in death)	Due to (or as a consec							0	
E	Examiner	L	Sequentially list conditions, b						laryland 21053 20c. Location - City or Town, State Towson, Maryland Vson Funeral Home, Inc. Maryland 21204			
	be sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	quence ot):							
_	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events cresulting in death) Last	Due to (or as a consec	quence of);							
760,		cal E										
687	ficate g phys ts the											
Box	nding use a	M	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregn		76			23	d. Date of deliv	rery	
	death certifica e attending ph id for use as th	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of c		⊒Ectopic pregnancy ⊒ Other (specify)				Month	Day h	rear
P.O.	that the de ed by the detached	hys	9 🗆 Unknown	9□ Unknown								
	requires that the leen signed by th hould be detache	by P	Part II. Other significant conditions con	tributing to death but not res	sulting in the u	inderlying cause giv	en in Part I.		_	e contribute to		
ord	w requires t been signe should be							- 10'	Yes 2	No 3□Pro	bably 4 □L	Jnknown
ecc	law as b	ompleted						24a. Was	osy	24b. Were autoprior to co	opsy findings a	
Vital Records,		Cou						perfo 1 ☐ Yes	med? 2 X No	death?	2□ No	
/ita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		Oth		Death (Check only o				
of	this aldir	2	1 ☐ Yes 2 No	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatie			Home 5 ☐ Resid	dence 6	Other (Speci	(20H) (M	016
	ing Viter une	들	1 Natural 5 ☐ Pending	(Month, Day Yeer)	Injury	Wor	k? Yes 2 ⊟No	200. 50001150	no tr inqui y	00001100	70	
Division	or Attending after death. I Director: After d in by the fune	fica	3 Suicide 6 Could not be	28e. Place of Injury - At h		reet, factory, office		28f. Location (S		Number or Rur	al Route Num	ber,
S	P F P	Certification;	4 Homicide	building, etc. (Speci	ity)			City or To	wn, State)			
	the Hospital or Attanding 24 hours after death the Funeral Director; Andletely filled in by the fi		29a. Certifier 1 Certifying Phys	sician: To the best of my known: On the basis of examination	owtedge, dear	th occurred at the tin	ne, date and pta	ace, and due to the	cause(s) a	nd manner as	stated.	
7	To the Hos within 24 h To the Fur completely	edical	one)	and manner stated.	ation and/or in							,
_	To the within To the	Σ	29b. Signature and title of certifier	1-0		29c. Licens				signed (Month,		
,	1)		1/1 Horthany	Muley, in	0	DJ.	7 307		UMU	UAry 1	1000	7
	Ot'		30. Name and address of person who	mpleted cause of death (Ite	m 23a) (Type	Print) St. G	20 P.L.	in 1 7	170	~		
	<u> </u>	200	31. Date filed (Month, MA) Year) 20	0.4 32. Registrar's Sign	ature	8 J, L	acro.	riid C	. 4.07			
	Sta Regist		ORIN I T ZU	04 32. Kegistrar's Sign	13 A	MAN						

MX00:6 40/11/1

			State of Maryland / Department of Health and N 1 - State Registrer Certificate of Death		ene 2 0 0 4	00652
	Physici	an	Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day 8 2 Year 4	3. Time of Death
	/Medic	al	4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	Jalunn	4c. County of Death	12:16AM
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	1 / 12 9. Births	place (State or Foreign
	Funeral Director	c	220-36-5871 HEM 20F 62 Yrs. Months Days Hours Min.	(Month, Day,)	rear) Cour	ntry)
	tryland thow		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	<u></u>	1	Od. Inside City Limits
	the Ma 28a-f s	Director	MANY/MAD W/B BB/ FI HOTE 10e. Street and Number 10f. Zip Code	100	g. Citizen of What Cour	1 No 2 No ntry?
	death with the Maryland ms 23s or 28s-f show rmust be notified at		2752 Trucky Ave 21218		USA	
\bigcirc	rs after death with the Marylan , or Itams 23s or 28s-f show raniner must be notified at	Funeral	11. Marifal Status 1	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
47	8 2 4	ed by	3 Wildowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation	16	Specify: Solution Specify: Specify: Solution Specify: Solution Specify: Solution Specify: Solution Specify: Spe	dustry
215	within 72 hours ene. than "netural", be Medical Era	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of work life. DO NOT use retired)	king		0
and 21	il Hygier other ti	Be Col	17 Father's Name (First, Middle, Last) SKI PPING CIE & Sc. 18. Mother's Name	e (First, Middle, Ma	NO COP	of W.
arylar	s 1 and 2 should be filed within 72 h I Health and Mental Hygiene, itam 27 is markad other than "natu other traumatic event, I'm Medical	TO 8	19a. Informant's ame/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run		City or Town State Zin	Codel -3/3 / P/
Man.	1 and 2 sho Health and Ism 27 is m	1	Dorothy Lawan 2782 Tively fee	Bulhas	& Mary	lows
Nore	ages 1 and of He		1) Seurial 2 Cremation 3 Removal from State cemetery, crematory or other place)	Date 20	De. Location - City or To	own, State
altin	permit. Pages Department of Important: If i any Injury or once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service icensee 22. Name and Address of Facility 64 52 (40 Let √ Existence)	ATMAN-	HARIS	Fundament Him
~ 60	80558			mo 21.	t.	Approximate
	Physician		Immediate Cause (Final Condition Con	Je	,	Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence of): ENG-Stack Peual Clistocite	,	`	> Zwas
30	po iii	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events.) Due to (or as a conse) nce of): Due to (or as a conse) nce of): MULLIPS			
ć.	be executed iician and burial-transit	Examiner	c. Due to (or as a consequence of):		U	ullem
8760,	cate ohys the	dlcai	d			
9 xo	h certifi ending r use as	0	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of delive	,
О.	the deat y the att ched fo	ysick	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Month	Day Year
Division of Vital Records, P.O. Box	Attending Physician: The law requires that the death certific refeath. sctor: After this certificate has been signed by the attending Is by the funeral director, page 2 should be detached for use as	Completed by Physiclan/M	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.		cco use contribute to the	
cord	w requir	leted		1 Yes 24a. Was an	24b. Were auto	osv findings available
I Re	The lav	Comp		autopsy performe 1 ☐ Yes	death?	mpletion of cause of 2□ No
Vita	/sician: s certific director,	To Be	examiner? Hospital: Other	th <i>(Check only one)</i> ome 5 ☐ Residen	ce 6 □Other (Specifi	v)
n of	ing Phy After thi uneral o	lon: T	27. Manner of Death 28a. Date of Injury 28b. Time of 1njury at 10 Natural 5 □ Pending (Month, Day Year) 28b. Time of 1njury 2b. Time of 1njury 2b. Time of 1nju	28d. Describe how		
visio	Attend or death actor: / by the f	Certification:	2 Accident	28f. Location (Stre City or Town,	et and Number or Rura	i Route Number,
Ö	Hospital or 24 hours afte Funaraf Dira tely filled in I		29a. Certifier 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place,			ated
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funaral Diractor: After this certificate ha completely filled in by the funeral director, page	Medical	(Check only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurrence) and manner stated.	red at the time, date	e and place, and due to	the cause(s)
	To t To t	×	29b. Signature and title of certifier Wildlica 29c. License number DS6399	290	I. Date signed (Month,	Dey, Year)
	U		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		11 2	1201
	Sta	ate	31. Date filed (Month, Day, Yeer) 32. Registrar's Signature	CIAILITY	NOSP.	
	Regist	rar	JAN 1 4 2004 Per Marie Andrews			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Marylar	•	te of Death		Reg. No. 200	4 00653
	Physic	an	1. Decedent's Name (First, Middle, Las	"			2. Date of Dee Month	Day Yes	
	/Medi Examii		4e Fecility Name (If not institution, give	street end number)	March	4b. City, Town, or	Location of Death	4c. County of D	
	Funeral Director		5. Social Security Number 6. Se	7. Age (In yrs.	. last birthday) If Dnd Yrs. Months	er 1 Year If Under 24 Hrs s Deys Hours Min.		Yeer)	Birthplace (State or Foreign Country)
		-	Usuel Residence of Decedent 10a. Stete 10b. County	10c. C	ity, Town or Location				10d. Inside City Limits
	r 28a-f show	.	MD NA		Pa	Himore			1 Yes 2 No
	death with the Marylend one 23a or 28a-f show r mast be notified at	i Direc	10e. Street end Number 827 N. Arli	notion AVE	#44 101. 2	2 1217		10g. Citizen of What	Country?
0	efter death or items 2 miner man	Ē	11. Merital Status 1 Never Married 2 Married	12. Wes Decedent Ever in L Armed Forces? 1 Xes 2 No	J,S. 13. Was Dec If Yes, sp 1 ☐ Yes	edent of Hispenic Origin? (Secify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, /hite, etc.
-005	2 hours ntural', cel Exe	ed by	3 Widowed 4 ☐ Divorced 15. Decedent's Edit	Year or Dates:	16a Decedent's Us	ual Occupation	di-	16b. Kind of Busine	SIACK ess/Industry
Maryland 21215-0020	d within 72 hours efter giene. or than "natural", or ite	Be Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	1 1	vork done during most of wo use retired)		Dome	stic
and	2 should be filed wit end Mental Hygiens is marked other the aumatic event, the	Be (17. Father's Neme (First, Middle, Last) (Unknown)	Can	veiai E	18. Mother's Na	me (First, Middle,	Maiden Sumame)	
laryl	s 1 end 2 should be Health end Mental tem 27 is marked o other traumatic ev	5	19a. Informant's Name/Relationship (7			ss (Street and Number or R	, A 1	r, City or Town, Stat	e, Zip Code)
	es 1 end 3 of Health Item 27 I	-	KEV KEGINGO 20a. Method of Disposition	LEE	Place of Disposition (N	ame of	t, Ande	20c. Location - City	or Town, State
Baltimore,			1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	Arbutus	Cemetery,	01-15-04	Baltin	nore, MD
Balt	permit. Pege Department of important: if any injury or once.		21. Signature of Funeral Service Licens	The way	22. Name	and Address of Facility W	Ho t	Greene Pallimore	Funeral Service
I	76 ∰	П	23a. Part1. Enter the discusse, or composhock, or hear failt re. List only of	lications that caused the dea	th. Do not enter the m	of dying, such as cardia	c or respiral ory ar		Approximate Interval Between Onset and Death
7	Physician /Medical		Immediate Cause (Final disease or condition		myelor	~~			
	Examiner	ē	resulting in death)	Due to ((or as a consequence o	f):			1
	executed n end el-transit	edical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b Due to (or es e consequence o	f):			
68760,	ificete be executed g physician end es the bunel-transit	edical	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or es a consequence of	·):			
Box (v requires that the death certifi been signed by the attending should be deteched for use es		•	d			ART PART		
	the dea y the at sched fo	ysici	Part II. Other significant conditions co	ntributing to death but not re	sulting in the underlying	cause given in Part I.			ute to the cause of death? Probably 4 Unknown
S, P	es that igned b be dete	by Pi					-	/	b. Were autopsy findings
cord	s been s 2 should	Completed by Physician/N					24a. Was perfor	an autopsy 24 med? 24	available prior to completion of cause of death?
al Re	sician: The lew certificate hes b director, page 2 s	Com					- NOY		1 ☐ Yes 2 ☐ No
Zi.	ysician is certifi directo	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatient 3☐ I	Others	eath <i>(Check only o</i> Home 5 ☐ Resid		Specify) hosping
Division of Vital Records, P.O.	To the Hospital or Attanding Physician: The lew requires that the death certificate be executed within 24 hours effer death. To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be deteched for use es the buriel-transit	Medicai Certification: To	27. Menner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	1	now injury occurred	
Divisi	i or Atter efter des Director d in by th	ertifica	3 Suicide 6 Could not be determined	28e. Plece of Injury - At l building, etc. (Spec	home, farm, street, factify)	ory, office	28f. Location (S City or Tow		r Rural Route Number,
	To the Hospital or within 24 hours effe To the Funeral Dir. completely filled in	dicai C	29a. Certifier (Check only one) 1 Certifying Phy Medical Example 1	rsician: To the best of my kn Iner: On the basis of examin and manner steted.	owledge, deeth occurre etion and/or investigation	ed et the time, date end plac on, in my opinion, death occ	e, and due to the ourred at the time,	cause(s) and manne date and place, and	r es steted. due to the cause(s)
	To the Within To the	Me	29b. Signature and title of certifier	and the state of the state of	2	29c. License number		29d. Date signed (M	onth, Day, Year)
	/) Sin		One (Terra Brief)	D4089		1/2/	
	5		30. Name end address person who	completed cause of death (Ite	SOL	St Pul Ph	e Ba	Huer	21203
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrer's Sign	Locks	,			

		1	For State Registrar		State of Ma	aryland		irtment of F tificate of	lealth and M <i>Death</i>		giene 2 (004	00654	
	Physicia		1. Decedent's Name (First, Mid	dle, Last)		•	-	LEVINE		2. Date of De. Month JANUAR		2004	3. Time of Death 10:17 P M	
	/Medic Examin		4a. Fecility Name (If not institute		treet and number)				r Location of Death	Ormorn	_	ty of Death	10.17	
	CXAIIIII	ÇI	1106 SCOTTS	HILL	DRIVE				BALTIMO				IMORE	
	Funeral Director		5. Social Security Number 212-12-2299	6. Sex 1 □	л 2 Д F 7. Age	e (In yrs. la	ast birthday) O Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da APR.1	, 1918	9. Birthp Cour	place (State or Foreign MD	
	D		Usual Residence of Decedent 10a. State 10b. Coun	tv		10c. City	, Town or Lo	cation				1	0d. Inside City Limits	
	Maryla	ţŏ	MD	BALTI	MORE		BAL ⁻	TIMORE					1 ☐ Yes 2 ☐ No	
	r 28a	irec	10e. Street and Number					10f. Zip Code			10g. Citizen of	What Cour	ntry?	
	death with the Maryland	raic	1106 SCOTTS				- 1		21208		14 0	ce - Americ	U.S.A.	
	I within 72 hours after death with the Marylan plane. I then "natural", or items 23a or 28a-f ehow then Medical Examiner must be multiped at the Medical Examiner must be multiped at	by Funeral Director	11. Marital Status 1 □ Never Married 2(X) M	rried	I2. Was Decedent I Armed Forces? 1 ☐ Yes 2 📜 If Yes, Give		1	Was Decedent of F f Yes, specify Cubi 1 ☐ Yes 2 ☒ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecity Yes or No Rican, etc.)	Spec	ack, White,		
2-003p	hours itural',		3 ☐ Widowed 4 ☐ Divorce		Year of Dates:		16a. Dece	dent's Usual Occup	pation		16b. Kind of	Business/In		
Ç	within 72 ene. then "nei he Medic	Completed	(Specify only high	est grade	College (1-4or 5	i+)	(Give life. l	kind of work done DO NOT use retire	during most of work d)	ing				
N.	filed wit Hygiene other the	Com	Elementary/Secondary (0-12				B00KI	KEEPER	18. Mother's Name	a /First Middle	ACCOUN			
and	d fa b	Be	17. Father's Name (First, Middle I SRAEL	e, Last)			MERV:	7	ANNA	e (First, Middle,	Maiden Suma	une)	KLEIN	
>	s 1 and 2 should be I Health and Mental Item 27 Is marked o other traumatic ev	၉	19a. Informant's Name/Relation	nship (Ty)	pe, Print)				and Number or Rur	al Route Numb	er, City or Town	n, State, Zip		
2	7.2 € d		SEYMOUR LEVI	NE /	HUSBAND				ILL DRIVE	The second secon				
altımore,	ges 1 ar of Hea If item or other		20a. Method of Disposition 1 X Burial 2 ☐ Crematio	n 3 □R	emoval from State	CE	emetery, crei	sition (Name of matory or other pla	ce)	Date	20c. Location			
Ē	t. Pages ntment of l rtant: If it njury or o		`4 ☐Donation 5 ☐ Other	(Specify)		CHI		MUNO ARL I 2. Name and Addre	NGTON 1/1				RE, MD	
Ba H	permit. Pages Depertment of I Important: If its any injury or o		21. Signatura of Funeral Servi	为	evi		8	3900 REIS	TERSTOWN		PIKESV:		MD 21208	
П			8900 REISTERSTOWN ROAD - PIKESVILLE, MD 2120 23a. Part f. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betwee Onset and Death Cause (Final).											
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	1/2	eile	-						minuelle	
	Examiner				Due to (or as	A S	CUL						YCC	
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	,	Due to (or as	a consequ	uence of):							
	icate be executed physicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	•	Due to (or as		inger of):							
8760,	be exi	al Ey	resulting in doutin cast	ı	Due to (or as	a consequ	derice or).							
687	ficate phys s the	edicai			1									
ŏ	death certifi e attending id for use as	m/M	IF FEMALE: 23b. Was decedent pregnant	2	3c. If yes, outcome			∃Ectopic pregnanc	v			ate of deliv	ery Day Year	
P.O. Box	0 0 0	Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown		4☐Pregnant at 9☐Unknown			Other (specify)			^	NOVATI	Day Year	
	The law requires that the tee bas been signed by thoage 2 should be detache	/ Ph	Part II. Other significant cond	itions cor	ntributing to death b	out not resu	ulting in the u	inderlying cause gr	ven in Part I.	23e. Did t	obacco use co	ntribute to t	he cause of death?	
rds,	quires n sign ald be	d by	ChroNe	A	trial	File	11/1a	1000		10	Yes 2☑No	3 ☐ Proi	oably 4 Dunknown	
S	aw require is been sig 2 should b	Completed	mild o	ON	\dol{A}'					24a. Was		. Were auto	ppsy findings available impletion of cause of	
ž		Com		•							ormed?	death?		
Vita	ician certifi ector	Be	25. Was case referred to med examiner?	211	Hospital:			Ot	26. Place of Dear					
ō	Attending Physician: r death. sctor: After this certification the funeral director.	To :u	1 Yes 2 No 27. Manner of Death	- 1	1 ∐ Inpation 28a. Date of Inju (Month, Da		28b. Time o		her: 4 Nursing He		how injury occi		(y)	
o	nding ath. r: Afte e fune	atior	1 ☑Natural 5 ☐ Per	ding stigation	(Month, Da	y Year)	Injury		rk?]Yes 2□No					
Division of Vital Records,	or Atterder des Directo	Certification:		ld not be ermined	28e. Place of In building, e	jury - At ho tc. <i>(Specif</i>)	ome, farm, st	reet, factory, office			Street and Nur wn, State)	nber or Rur	al Route Number,	
<u> </u>	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this is completely filled in by the funeral direction	edical Co	(Check only 2 Media	ying Phy al Exami	ner: On the basis of	f examina	wledge, deat	h occurred at the to exestigation, in my	ime, date and place, opinion, death occui	, and due to the rred at the time,	cause(s) and r date and place	manner as s e, and due t	stated. o the cause(s)	
1	o the ithin 2 o the omplet	Med	one) 29b. Signature and title of cer	ifier	and manner st	aleu.		29c. Licen	se number		29d. Date sign	ned (Month,	Day, Year)	
					mm			00	00470	1	1/11	104		
	10			_		death (Iten	n 23a) (Type,	Print)	1 1.11			N Cir		
			S: H. MAL 31. Date filed (Month, Day, Ye	PUC) E	J 365	S O	Idll	cest si	of 15Alto	· mod	212	UJ		
-	Sta Regist		30. Name and address of pers S; H: IMAL 31. Date filed (Month, Day, You	2004	Steel 14	M	Con	E.						

			1 - For State Registrar	State of M	arylan		artment rtificate				•	giene Reg. No. (2004	00655
The state of	Physic /Medi		Decedent's Name (First, Middle, Last John E. Mo	ore							2. Date of Dea Month January	ath Day	2004	3. Time of Death 4:00 P M
	Exami		4a. Fecility Name (If not institution, give Laurel Regional H	ospital	,,]	Laur				Pr	ounty of Death	eorges
	Funeral Director		5. Social Security Number 6. Se 216-24-9291	X XM 2□F	9 (in yrs. 7:	last birthday) 5 Yrs.	If Under Months	Days	Hours	Min.	8. Date of Birt. (Month, Day May 14,	r, Year)	Con	place (State or Foreign intry) nington, D.C
	ne Maryland Ba-f ehow	ctor	10a. State 10b. County Maryland Anne Ar	undel	10c. Cit	y, Town or Lo Jessur								10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with the	al Dire	10e. Street and Number 2964 Jessup Road				10f. Zip	Code 2079	94				in of What Cou Lted St	,
036	d within 72 hours after death with the Maryland jiene. I than "natural", or Items 23e or 28e-f ehow the Madical Examples must be multiped at the Madical Examples.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent Armed Forces? 1 Types 2 1 If Yes, Give Year or Dates:			Was Deced f Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)	14	Race - Ameri Black, White,	can Indian,
Maryland 21215-0036	within ane. than	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		i+)	life. L	dent's Usual kind of work DO NOT use 1 Car	k done di e retired)	uring most	of worki	ing		of Business/Ir	,
yland 2	be file ntal Hyg od othe event,	To Be C	17. Father's Name (First, Middle, Last) Wilmer F. Moore						Jul:	ia S	(First, Middle, hehna	Maiden Su	umame)	
	t and 2 s Health ar Im 27 is		Nan Greaves - Step 20a. Method of Disposition	Daughter	20b. P	376 W	lashin	gtor	Scho	001	al Route Numbe House_Ro Date	1. R		21911 Sun, MD
Baltimore,	permit. Pages Department of the Important: If Ite eny injury or of once.	8	1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Removal from State (Specify) 22. Name and Address of Facility Gary L. Kaufman Funeral Removal from Blv											Maryland
8760,	Physician /Medical Examiner	al Examiner	23a. Pert1. Enter the dispase, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Bronche Due to (or as Due to (or as Due to (or as	D-PNE a consequ C Obs a consequ	eumonia uence of): structi	er the mode	of dying	, such as o	cardiac o	r respiratory arr	cidge est,		Approximate Interval Between Onset and Death Wo Days.
.O. Box 687	death certif e attending id for use a:	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 🗌 Fetal	death 3 🗌	Ectopic pre Other (spe					230	d. Date of delive	ery Day Year
<u> </u>	sign sign d be	þ	Part II. Other significant conditions cor	ntributing to death bu	ıt not resu	ulting in the un	derlying ca	use giver	n in Part I.					ne cause of death?
Division of Vital Records,	The law ate has b page 2 si	Completed							· · · · · · · · · · · · · · · · · · ·		24a. Was a autops perform	y ned?	prior to con death?	psy findings available mpletion of cause of
f Vits	yslcian: Th is certificate director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🖾 No	fospital: 1 ☐ Inpatie	nt 2 1 5] 8	ER/Outpatient	3□ DOA	0	_		(Check only on	-	Other (Specif	
sion o	To the Hospital or Attending Physician: within 24 hours after deals after deals for the Funeral Director. Attenthis certific completely filled in by the funeral director.	atlon: T	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injur (Month, Day	y	28b. Time of Injury		c. Injury a		2	8d. Describe ho			,
DİVİ	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by t	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc							City or Town	, State)		l Route Number,
	To the Hospital within 24 hours a To the Funeral I completely lilled	Medical	29a. Certifier 1 M Cartifying Phys (Check only one) 2 Medical Examin	nar: On the basis of and manner sta	examınati	vledge, death ion and/or inv	estigation, i	n my opii	nion, death	place, a occurre	d at the time, da	ate and pla	ice, and due to	the cause(s)
)	1 × 5 g		29b. Signature and title of certifier	Delles	Ve-		> D	304				ed. Date si	igned (Month, I	
	10			055 Chevr	olet	Drive		0, E	llico	tt c	ity, MD	2104	12.	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	r's Signati		29 2							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2004 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ACKIE WALLACE Month Day Year **Physician** 4.55 AM JAHUHRY 11 2002 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE GOOD SAMARITAN HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex/ 1 M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Days Hours NORTH C 216.62.0128 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Examiner must be notified at BALTIMORE MD 1 X Yes 2 No Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö U.S.A. 21202 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Caban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: Specify: BLACK 1 Never Married ŏ 1 ☐ Yes 2 M No 21215-0036 3 Widowed 4 Divorced 'natural', ar then "natura". It is Mudical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cottege (1-4or 5+) ABORER Pages 1 and 2 should be filed 18. Mother's Name (First, Middle, Maidem Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Las. Be Mentai le marked 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) BATIMORE, MO 21206 permit. Pages 1 and 2 Department of Health ar Important: If Item 27 le ony injury or other trau WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State BALTIMORE, MARYLAND 4 □ Donation 5 □ Other (Specify) VAUGHTN C. GREENE FUNDEAU HOME 22. Name and Address of Facility 21. Signature of Funeral Service License ROAD BATIMORE, MARILAND 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS 2 WEEKS **Physician** /Medical Due to (or as a consequence of): **Examiner** BACTERIAL 2 WEEKS ITI GAASOBHS Sequentially list conditions. r any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ REMAL 1 Yes 2 No 3 Probably 4 Nunknown 24b. Were autopsy findings available prior to completion of cause of death? FRONTAL HEMATOMA 24a. Was an page 2

The law requires that the death certificate be executed Division of Vital Records, or Attending Physicien: Be Completed autopsy performed? EJAC 1 Yes 2 No MOITEL 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient Certification; To 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3□ DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated.

To the.
within 24 hour.
To the Funeral Di

JAN 14 31. Date filed (Month, State Registrar

EKNyonator,

29b. Signature and title of certifier

MYOHATOR 32. Registrar's Signature

2M

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LOCH RAVEM BOULEVARD

G-005

29c. License number

RES DOD

SAMARITAN

1 ☐ Yes

29d. Date signed (Month, Day, Year)

HORNVITAL

JAHUARY 11, 2004

MB 21236

director

filled in by

this funeral

death. hours after death uneral Director;

لتبرع		State Registrar Amend It					-	2.	Date of Deat Month	h Day		3. Time of Death
ysician Iedical		Nannie Pris	cilla M	EEKS					Jan.		2004	12:05 P
niner		a. Facility Name (If not institution	give street and nur	mber)		4b. City, Town,				1	County of Deat BALTIM	
		3430 CHRISTOPH			to a brakato		ACRES		Date of Birth			
		. Social Security Number 182-20-9204	6. Sex 1 ☐ M 2 ☐ X F	7. Age (in)	rs. last birthday	Months Days		Min. 1	(Month, Day, 0/31/1	7 (ar) 925	PEN	hplace (State or Fore junity) INSYLVANIA
	-	Usual Residence of Decedent 10a, State 10b, County		10c	. City, Town or	Location			-			10d. Inside City Lim
5			GOMERY		PENLLYN	ī						1 □ Yes 2 🛛
Director	3	10e. Street and Number	00110111			10f. Zip Code	-		1	0g. Citiz	zen of What Co	ountry?
	5	1135 TREWELLYN	AVENUE			1942	22			1	USA	
STOC	Laurela	11. Marital Status	12. Was Dec	edent Ever	in U.S. 13	3. Was Decedent of If Yes, specify Cu		igin? (Specif	y Yes or No-	1	4. Race - Ame Black, Whit	
	2	1 Never Married 2 Marr 3 Widowed 4 ∰ Divorced		2 🔯 No ve		1 ☐ Yes 2 💢 No			,		Canaiha	BLACK
4	2	15. Deceden	s Education		16a. Dec	cedent's Usual Occi ve kind of work don	upation	st of working		16b. Kir	nd of Business	Industry
o co	- <u>5</u>	(Specify only higher Elementary/Secondary (0-12)	College (life	. DO NOT use retir	ed)	at or working		ואנוס	RMACEUT	TCALC
5	Completed		2 YEARS	5	_ _ I	NSPECTOR						TOALS
0	DG	17. Father's Name (First, Middle,		~			18. Moth	•	First, Middle, i	Maiden .	Sumame)	
	2 _	GEORGE HERBER		S					ES LEE	0::	T 04-1-	T. Code)
		19a. Informant's Name/Relations EDWARD MEEKS	iip (Type, Print)	SON		illing Address (Street)						ын, РА 1 52
		20a. Method of Disposition 1 Burial 2 □ Cremation	3 Removal from	State 20	b. Place of Dis cemetery, c	position (Name of rematory or other p	ace)	Date	0	20c. Lo	cation - City or	
		* 4 □Donation 5 □ Other (S	pecify)	F	ROSE VAI	LLEY CEME		1/17/		_	ER, PA	
	1	21. Signature of Funeral Service	icensee.			22. Name and Add						HOME, P.A
_	-	32 Part Effer the disease, or			deeth Do set	8521 LOCI	_				, MD ∠	Approximate
	Exa	disease or condition resulting in death) Sequentially list conditions, and any to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Co Due to	or as a cor	nsequence of):	Cerno	m=0.	nerry				
	edicai		d							- 1-		
	Dy Physician med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		birth 2 🗍 nant at time	Fetal death	3 □Ectopic pregnar 5 □ Other (specify)				2	23d. Date of de Month	livery Day Year
3	<u>></u>	Part II. Other significant conditi	ens contributing to	death but no	t resulting in the	underlying cause	given in Part	1.	23e. Did to	bacco u		o the cause of death
7	D	Ceresal	verco le	- A	CCIAn	+			1 🗆 Y	es 2[□No 3□P	robably 4 2 Unkno
Acto	Completed	Bruce C	encan						24a. Was a	sv	24b. Were a	utopsy findings available completion of cause
-	E								perfor 1 ☐ Yes	med?	death?	2 No
,	a)	25. Was case referred to medica					26. Plac	e of Death (Check only o	ne)	PERSON FOR	CT CURICE
	TOB	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1	Inpatient	2 ER/Outpat	tient 3 DOA	Other: 4 D N	7				SIDENCE
	tion:	27. Manner of Death 1 Natural 5 Pendi 2 Accident Invest		of Injury nth, Day Yea	ar) 28b. Time Injur	у И	juryat /ork? □Yes 2 □		d. Descri be h	ow injur	y occurred	
B - B	Certification:	3 Suicide 6 Could 4 Homicide determ	inad 200. Flac	e of Injury - ding, etc. (S	At home, farm, pecify)	street, factory, offic	e	28	f. Location (S City or Tow			ural Route Number,
	Medicai C	29a. Certifier (Check only one) Certifyi Check only 2 Medical	ng Physicien: To the	ne best of my basis of exa nner stated.	y knowledge, de mination and/or	eath occurred at the	time, date a y opinion, de	and place, an eath occurred	d due to the d at the time, d	ause(s)	and manner a place, and du	s stated. e to the cause(s)
1	Mec	29b. Signature and title of certific				29c. Lice	nse number			29d. Dat	e signed (Mon	th, Day, Year)
13	- 1											
			and .							Jon		2 00 4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 1 1 L Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dev Month Year 12, 2004 3:45am January Morris Margaret 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Maryland Timonium Stella Maris Hospice If Under 24 Hrs. Hours Min. 8. Date of Birth Allg • 1911 Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Months Days 1 M 2 TXF 92 Yrs. 215-10-1967 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2 1 No Eldersburg MD Carroll 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21784 6415 Tamarack Circle 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. White 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2F No If Yes, GiveA Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 HNo Specify: Specify Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Isabella Kirby Rutherford B. Heise 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) Mrs. Margaret C. Glauser (Daughter) 6415 Tamarack Circle Eldersburg, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/15/2004 Baltimore, MD New Cathedral Cemetery 21. Signature of Funeral Service Licensee HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the ceuse of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Pes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy level Jas-bliebene 1 ☐ Yes 2 ☑ No 1 T Yes Hemic 25. Was case referred to medical examiner? 26. Piace of Death (Check only one)

Examiner The law requires that the death certificate be executed Physician/Medical as the the attending use sete hes been signed by the a page 2 should be detached þ

Be Completed

ဥ

Certification:

Medical

Physician

/Medical

Examiner

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Medical Examinar must be notified at

nd Mental Hygiene. marked other than

. Pages 1 and 2 should be fill ment of Health end Mental Hyant: if Item 27 is marked oth

Depertment

Physician

/Medical **Examiner**

other

= 5

Funeral Director

à

Completed

Be

filed within 72 hours after death with the Marylend

Baltimore, Maryland 21215-0020

Box 68760.

PO

Division of Vital Records.

certificete

To the Hospital or Attending Phys within 24 hours after death.

To the Funerei Director: After this

funeral director,

completely filled in by the

1 Yes 2 No 27. Manner of Death

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 Matural 2 Accident

28a. Date of Injury (Month, Day Year) 5 Pending investigation

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29a. Certifier

1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of ceftifier

29d. Date signed (Month, Day, Year)

1 r.5 to

31. Date filed (Month, Day, Year)

2004

てっんカッ 32. Registrar's Signature

South Herose Street Wellingie 17

State Registrar

DHMH 16 Rev 6/95

			1 - For State Registrar	State of Maryland /	Department of Hea	alth and Mental	Hygiene 2 0 0 L	+ 00659
	Physici	an	Decedent's Name (First, Middle, Last	, , , ,	2:15	2. Date	of Death	3. Time of Death
	/Media	al	4a. Facility Name (If not institution, give	Street and number)	4b. City, Town, or Loo	O1	4c. County of Dea	
	Examir	ier	3725 Fieldston	e Road	Rando	Ulstown	Ba	Himre
8-7	Funeral Director		5. Social Security Number 6. Se	x 7. Age (In yrs. last.		Under 24 Hrs. 8. Date of Mont	of Birth h, Day, Year) 9. Bi	rthplece (State or Foreign ountry)
	Q .	•	Usuel Residence of Decedent			1 104	11-30	
	Marylar f show	ō	10a. State 10b. County		andallstown			10d. Inside City Limits 1 ☐ Yes 2 No
	th the or 28a-	Funeral Director	10e. Street and Number	TOPE TR	10f. Zip Code		10g. Citizen of What C	ountry?
	s 23a	ral	3725 Fields	one Road	21	133	USA	in the discount of the control of th
ထ	after de or itam	Fune	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ever in U.S. Armed Forces? 122 Yes 2 □ No		lexican, Puerto Rican, etc	or No- c.) 14. Rece - Am Black, Wh	
00 00	hours a	ρ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		pecify:	Specify: P	BACK
215	be fited within 72 hours after death with the Maryland lat Hygiene. Id other than "natural", or Itams 23a or 28a-1 show adother than "natural", or Itams 23a or 28a-1 show avent, it a Medical Exactive minal be rodified at	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0·12)		ia. Decedent's Usual Occupation (Give kind of work done durin life. DO NOT use retired)	g most of working	16b. Kind of Business	s/industry
21	ted with		12th GRADE	4 YRS.	Atheletic 1)irector	Educa	Hional
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23e or 28e-f show any injury or other traumatic avent, the Medical Experiment must be rediffed at ODGs.	To Be	17. Father's Name (First, Middle, Last)	Drice.	18.	Mother's Name (First, M.	Iddie, Maiden Sumame)	
lary	2 should and Men is marks raumatic	-	19a. Informant's Name/Relationship (T)		9b. Mailing Address (Street and I	Number or Rural Route N	lumber, City or Town, State,	Zip Code) 21133
	1 and Health em 27		20a. Method of Disposition	Urn (Wife) 20b. Place	of Disposition (Name of	tone Ku	20c, Location - City of	Town, Stete
Mo	Pages nent of int: If it		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify,	temoval from State / I	rison Furest	01-16-0	4 Owings 1	Milk M
Baltimore,	permit. Departn Imports any inju		21. Signatur of Funeral Service Licens	00	22. Name and Address of		alto. Notion	of Pike
	40394		23a. Pert1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the death. D	o not enter the mode of dying, su	YEENE Funeral		Approximate
1	Physician	3 9	shock, or heart failure. List only of Immediate Cause (Final disease or condition	ne cause on each line.	mia			Interval Between Onset and Death
4	/Medical Examiner		resulting in death)	Due to (or as a consequence	عدم ما داه			12
-		ler	Sequentially list conditions,	Due to (or as a consequence	e of):			15 years
	Bcuted and transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.				
8760,	icate be executed physicien and s the burial-transit	dlcal E	(System) we down / East	Due to (or as a consequence	e or):			
9	rtificate ng phy: as the	Medic	IF FEMALE:	0.				The state of the s
Вох	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death	th 3 Ectopic pregnancy 5 Other (specify)		23d. Date of de Month	livery Day Year
o.	thet the de ed by the detached	hysic	1 Yes 2 No 9 Unknown	9 Unknown	5 Ditter (specify)			
S, D	w requires the s been signed t s should be det	by P	Part II. Other significant conditions co	ntributing to death but not resulting	in the underlying cause given in		Did tobacco use contribute t	o the cause of death?
Records,	w requi	leted					•	utopsy findings available
	Physician: The lav this certificate has al director, page 2 a	omo					autopsy prior to performed? death?	completion of cause of 2 No
Vital	Physician: rthis certifica ral director, p	Be	25. Was case referred to medical examiner?	Hospital:	Other	Place of Death (Check of	only one)	
Division of	g Phys er this eral dir	n: To	27. Manner of Death	1 Inpatient 2 EHV	Time of 28c. Injury at		Residence 6 Other (Speribe how injury occurred	ocity)
sion	or Attending after death. Director: After in by the funer	catlo	1 ► Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year)	Injury Work? M 1 ☐ Yes	2 🗆 No		
Ω̈́	I or Att after d Direct I in by	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office		ion (Street and Number or R r Town, State)	ural Route Number,
_	To the Hospitel or Attanding Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the best of my knowled ner: On the basis of examination	ge, death occurred at the time, d	ate and place, and due to	the cause(s) and manner a	s stated.
	thin 24 thin 24 of the F	Medical	one) 29b. Signature and title of certifier	and manner stated.	29c. License nur		29d. Date signed (Moni	
)	F 3 F 8		> Charles	adgettus)	155	346	Jan 12.	2004
	10		30. Name and address of person who co	ompleted cause of death (Item 23a	(Type, Print)	RI.OT	Roll	111 2430
	Sta	te	31. Date filed (Month, Day, Years)	32. Registrar's Signature	Loca rave	VI DUCK,	LIUTIMOCO,	My 2459
	Registr		JAN 1 4 2004	Server B	Sporth			

				State of Maryla	ind / Dena	artment of F	Health and N	Mental Hvo	ieneo o o l	
			1 - For State Registrar	State 5. maryta	Cei	rtificate of	Death		eg. No.	00660
	Obvoio	ion	1. Decedent's Name (First, Middle, Last)				-	2. Date of Dea Month	th Day Year	3. Time of Death
	Physic /Medi		RICHARD	ALA	2 1	4055		JAN	11, 2001	1 18=20 M
	Exami	ner	4a. Facility Name (If not institution, give s		. 0		or Location of Death	n A	4c. County of De	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yr	s. last birthday)	If Under 1 Year	If Under 24 Hrs.	8 Date of Birth	O Bi	rthplace (State or Foreign country)
	Director		063-34-5933 ¹\text{\fit}	M 2□ F	63 Yrs.	Months Days	Hours Min.	MAR.5,	1940	NY
	pu s		Usuel Residence of Decedent 10a, State 10b, County	100.0	City, Town or Lo	eation				10d. Inside City Limits
	daryla f sho	ö	MD HARFO		ABER					1 ☐ Yes 2 ☐ No
	r 28e-	Funeral Director	10e. Street and Number	ND .	AULI	10f. Zip Code		1	0g. Citizen of What C	Country?
	th with	aiD	435 HOLIDAY DRIVE			:	21001			U.S.A.
	rdea	ner		Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
I	and 21215-0036 be filed within 72 hours after death with the Maryland tall thygiene. Individual then "neturel", or items 23e or 28e-1 show event, the Medical Examinat must be notified at	by Fi	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 🗖 Yes 2 🗍 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify:	WHITE
Q	Maryland 21215-0036 nd 2 should be filed within 72 hours aft this and Mental Hygiene. 27 is marked other then "neturel", or treumetic event, the Medical Expansion	ted	15. Decedent's Educ	ation	16a. Dece	dent's Usual Occup	pation		16b. Kind of Busines	
61	215 thin 7:	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)			oation during most of work d)	ing		
Ó	ed will ygien ygien t. Its	Completed		5+	PHAR	MACIST			PHARMACEU	TICAL
8		e e	17. Father's Name (First, Middle, Last) LEWIS		MOSS		18. Mother's Nam	e (First, Middle, i	Maiden Sumame)	CHADACH
	faryland	၉	19a. Informant's Name/Relationship (Type	oe. Print)			JEAN and Number or Bur	al Route Number	, City or Town, State,	CHARASH Zin Code)
_	Baltimore, Marylan permit. Pages 1 and 2 should be Department of Health and Menta Importent: If tiem 27 is marked eny jaury or other treumetic evone.		EILEEN MOSS / WIF						MD 21001	
0	altimore, mit. Pages 1 ar partment of Hea portent: if item 3 y injury or other ice.		20a. Method of Disposition	206		sition (Name of natory or other place			20c. Location - City o	r Town, State
-	Page Page ment c		1 ☐ Burial 2 ☐ Cremation 3 💢 Ro '4 ☐ Donation 5 ☐ Other (Specify)	BINOVALITUTII STATE	. SHARO	N CEMETE	RY 1/13	/2004	SPRINGFI	ELD, PA
1	Balt Depart mpout		21. Signature of Funeral Service License	9) <		. Name and Addre	50		ON & BROS	
-	m 90700		Jay (May)) eur					IKESVILLE	
	21		23a. Part V. Enter the disease, or bomble shock, or heart failure. List only on Immediate Cause (Final			er the mode of dylr	ng, such as cardiac	or respiratory arm	est,	Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	Due to (or as a conse	editence of).	-				
	Examiner			545 (5) 45 4 55 (5)	5q46166 61).					
	D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cause Cause to (or as a conse	equence of):						
	760, s be executed sictan and burial-transit	Examiner	that initiated events cresulting in death) Last	Due to (or as a conse	aguagaa of):					
	38760, icate be ex physician a	cal E		Due to (or as a conse	aquence or):					
3	# % # % #		d							
A	Vision of Vital Records, P.O. Box 68 Attending Physicien: The law requires that the death certifica or death. ector: After this certificate has been signed by the attending ph by the funeral director, page 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of preg 1□Live birth 2□Fe		T			23d. Date of de	alivery
1	P.O. Box	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of		Ectopic pregnancy Other (specify) _	y 		Month	Day Year
C	P.O	Phy	9 Unknown					00 - Did (-)		4
	ecords, P law requires that as been signed to	b	Part II. Other significant conditions con	Tributing to death but not re	_	* *				to the cause of death?
D	requires should	eted					4 6 12 7	;		
76	I Rec The law page 2 s	Completed	DINBERES	MULLITOS	1400	<u> </u>		24a. Was a autops perforr	y prior to ned? death?	utopsy findings available completion of cause of
CHARD	Vital Recipion: The lavecertificate has rector, page 2		25. Was case referred to medical				26. Place of Deat	1 Yes 2		s 25 No
0	Division of Vital Records, I or Attending Physicien: The law requires tafter death. Director: After this certificate has been signed in by the funeral director, page 2 should be	To Be	evaminer?	ospital: 1 Inpatient 2	⊠ ER/Outpatien	t 3□ DOA Oth			ence 6 □Other <i>(Sp</i> e	ecify)
8	ng Ph fter th		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		y at rk?		w injury occurred	
10	isiol kttendia death. ctor: A y the fu	Certification;	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				Yes 2 □ No	206 1		
SS	or At after of Direct in by	ertifi	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec		eet, factory, office		City or Town	reet and Number or F n, State)	lurai Houte Number,
0	spitel nours nerel	al C		ician: To the best of my k						
I	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely tilled in by the funeral director.	Medical		er: On the basis of examinand manner stated.						
	To ti withii To ti	Ž	29b. Signature and title of certifier	A A		29c. Licens			9d. Date signed (Mon	
	(7)		Manight m		.0	100000	21809		JANII,	2004
	1.6		30. Name and address of person who cou					Ma	2:005	
	C+	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sig		NO 110	MOHIOM		21093	
	Regist		IAN 1 4 2004	Blister St		y				

State of Maryland / Department of Health and Mental Hygiene 2001 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Dorothy Ohl 9, 2004 5:45am January /Medical 4e. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Crawford's Retreat Baltimore City Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 💢 F 89 Yrs. 218-07-2237 Director Oct 23 1914 Md Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event. The Medical Examiner must be notified at once. MdBaltimore City Baltimore 1 X Yes 2 ☐ No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2117 Dennison Street 21216 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) None None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry Schneider Theresa Moseman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2117 Dennison Street Baltimore, MD 21216 Patient Records Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Cemetery 1-14-04 Glen Burnie, Md 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee P.O. Box 195 Sykesville, Md 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Mesocaldeal Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 I Hursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification; To filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ed cause of death (Item 23a) (Type, Print) 30. Name and address of person who complet BALTO ANIL UBEROF 0 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 4 2004 Registrar

letty R Phillips

ion of Vital Records, P.O. Box 68760,

		For State	State of Maryland						04	00662		
		1 - State Registrar Amend Item #1 1. Decedent's Name (First, Middle, Las		1/04/61	incate of L	Jeann	2. Date of Dea	Rag. No.	- 1	3. Time of Death		
Physici	an						Month	Day	Year	2101 PM		
/Media		Elizabeth R. Phi: 4a. Facility Name (If not institution, give			4h City Town or	Location of Death	Januar	4c. County	XUU-	a con-		
Examir	ier				4b. City, Town, or	Location of Death		4c. County	oi Death			
		LORIEN @ RIVE 5. Social Security Number 6. S		t hirthday)	BELCAN If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	HARF		ace (State or Foreign		
Funeral Director		1	□M 2□F	Yrs.	Months Days	Hours Min.	(Month, Day	, Year)	Count	try)		
		186-16-1787 Usual Residence of Decedent	x 80				Oct. 6,	1923	renns	sylvania		
land ow		10a. State 10b. County	10c. City,	Town or Loc	ation				10	d. fnside City Limits		
Mary -(eh	ţ	Md. NJ Cape Ma	277	0cean	City					tx⊡Yes 2 ☐ No		
28a	Director	10e. Street and Number	ay	ocean	10f. Zip Code			10g. Citizen of W	/hat Count	try?		
3a ou		5537 Bay Avenue			08	226		United	State	96		
ns 2	Funerai	11. Maritaf Status	12. Was Decedent Ever in U.S.	13. V		spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No-		- America	an Indian,		
riter far	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2√ No				Rican, etc.)	Blac	k, White, e	itc.		
urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	☐ Yas 2√∏ No	Specify:		Specify	: wh	nite		
2 ho	Completed	15. Decedent's Ed	lucation	16a. Deced	ent's Usual Occupa	ation		16b. Kind of Bu	siness/Ind	ustry		
E	pie	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	kind of work done d OO NOT use retired,	furing most of work)	ing					
d with	E	Liomoniary/Sociality (STE)	2 years	adm:	inistrati	ve assis	tant	educa	tion			
ethe file	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Name		Maiden Sumam	в)			
Ked ice	ToB	John Rowles				Mabel 1	Robinsor	1				
shor nd N		19a. Informant's Name/Relationship (7	Type, Print)	19b. Mailing	g Address (Street a	and Number or Run	al Route Numbe	r, City or Town,	State, Zip (Code)		
nd 2 27 ls		Barbara Weber/da	ughter	3001	Winchest	er Way,	Fallstor	n, MD 21	047			
tem at the other		20a. Method of Disposition	20b. Plac	ce of Dispos	sition (Name of atory or other place	1	Date	20c. Location -	City or Tov	vn, State		
ages ant of t: Fi		1 Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specify	Removal from State	-	1		10%	Fa11a+a	- Ma	1		
in intro		21. Signature of Funeral Service Ocen			Mem. Gdns Name and Addres		704	Fallsto	II, MC	1.		
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Manial Hyglene. Department of Health and Manial Hyglene. Importent: If item 27 is marked other than "naturel; or items 23a or 28a-f ehow enty injury or other treumatic event, the Medical Evantinational be notified at once.		Dill & Ba	denis		Schimunek	Funeral						
		23a. Pert1. Enter the disease, or compensor, or heart failure. List only	ncations that caused the death.	Do not ente	r the mode of dying	g, such as cardiac	or respiratory arr	est,		Approximate Interval Between		
Physician		Immediate Cause (Final		1	//		1			Onset and Death		
/Medical		disease or condition resulting in death)	a. Due to (or as a conseque		Man	1 (011	CV P					
Examiner			`	mely.	a. Lo.	t fail						
	er	Securatistly list conditions if any, leading to immediate	Due to (or as a conseque		aueq	arto						
nsit	듣	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
axect and al-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a conseque	nce of):								
cate be executed only sician and the burial-transit												
the chart	dical		, d									
Heath certific	ician/Me	fF FEMALE:	23c. If yes, outcome of pregnance	v				22d Date	of deliver			
atter for u	iar	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetaf d 4 Pregnent at time of dea	eath 3 🗌	Ectopic pregnancy Other (specify)			Mon		y Day Year		
he d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	ai 5 <u>0</u>	Other (specify)							
ires that the de signed by the a	Physi	Part II. Other significant conditions of	entributing to death but not resulti	ing in the un	deriving cause give	en in Part I	23e. Did to	hacco use contri	bute to the	cause of death?		
signe be (þ	Change Chat	this Allman A	1. CO	a a		1 🗆 Y		3 ☐ Proba			
w require been sig should b	ted	Chound out to	(101 / 0/1409 /	15+00	٧			23 2 700	0	- Johanomi		
e law has b je 2 st	ğ						24a. Was a autops	SV D	rior to com	sy findings available pletion of cause of		
ysicien: The l is certificate ha director, page	Completed						perfori	med? de	eath? □ Yes 2			
icien: Th certificate rector, pag	Be (25. Was case referred to medical examiner?				26. Place of Death	n (Check only or	re)				
Physic this ce al dire	2	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ EF	R/Outpatient	3□ DOA Othe	ar: 4 Nursing Ho	me 5 Reside	ence 6 Othe	r (Specify)			
ig Ph Gerth Deral		27. Manner of Death	28a. Date of Injury 2: (Month, Day Year)	8b. Time of Injury	28c. Injury Work	at	28d. Describe he	ow injury occurre	d			
ath. Fr: Af	atic	1 Statural 5 Pending 2 Accident investigation		,,		res 2 □ No						
Atte	iţi	3 ☐ Suicide 6 ☐ Could not be determined	289. Place of injury - At nom	e, farm, stre	et, factory, office		28f. Location (St	reet and Numbe	r or Rural	Route Number,		
afte din din	Certification:	4 Hollicide	building, etc. (Specify)			4	City of Town	i, State)				
To the Hospital or Attending Physicien: The law requires that the death certification 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 Cartifying Ph	ysician: To the best of my knowle	edge, death	occurred at tha tim	e, date and place,	and due to the c	ause(s) and mar	ner as sta	ted.		
P 24	edicai	(Check only 2'☐ Madical Exaп one)	ninar: On the basis of examinatio and manner stated.	n and/or inv	estigation, in my op	oinion, death occurr	ed at the time, d	ate and place, a	nd dua to t	the cause(s)		
ro th ro th comp	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)										
) or l	1 Aller	her	01	7975		1/9/1	JV ·			
10		30. Name and address of person who	completed cause of death (Item 2	(3a) (Type F	Print)	1 (3		(((
1		^	Chrism 61	1	rac Mr.	o rd	196/ A	The MAIN	210	14		
Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	re	2.01		, 4 ()	(0.14)	~ ()			
Registi			4 2004	Lo	frank .	,						
		JAN_1	= CUUY CARRE	a Riv	A STATE OF THE STA	-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ames 10:25 PM 001 January 12 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore of Mongland University Hospita 6. Sex Jast birthday If Under 1 Year | If Under 24 Hrs. 7. Age (In y 8. Date of Birth Month, Day, 9. Birthplace (State or Foreign **Funeral** 10 M 20 F Days Hours Director Usual Residence of Deceden filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or Iteme 23e or 28a-f show Ite Medical Examiner must be notified at 10d. Inside City Limits Baltimore 1 ☐ Yes 2 ☐ No by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15a USA 2124 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 7 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Yes, Give ear or Dates: Black Specify: 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than (0-12) College (1-4or 5+) Maintenance 17 Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Sumame) of Health and Mental H I Item 27 Is marked oth r other traumatic even Be Pages 1 and 2 should be 400 ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1521 St. 3rdF Balto. Flance MD 21225 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Importent: If Ite any njury or of 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) cemetery, crematory or other place) Mt. Zion Cemeter 21. Signatur of uneral Servic L 22. Name and Address of Facility 21229 P. March FIH 270 Fredhilton Batto, mo East the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Lause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): hemmerhad Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit Due to (b) as a consequence of): P.O. Box 68760. attending physician for use as the buria Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 3 Probably 1 ☐ Yes 2 ☐ No 4 MUnknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? certificate 1 Yes 2 No 1 Yes 2 No 24 hours after death.
• Funeref Director: After this certific etely filled in by the funeral director. 25. Was case referred to medical exampler?
1 ☑ Yes 2 ☑ No Be 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 🗍 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Nospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 2 To the and manner stated 29b. Signature and title - ertifier 29d. Date signed (Month, Day, Year) Z004 pleted cause of death (Item 23a) (Type, Print) Street Deplortmen 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of Ma		nd / Depa	artme	nt of H					enni.	008	564
			1. Decedent's Name (First, Middle, La	st)		-				1	2. Date of Deat	_	V	3. Time of	Death
	Physici		ROSE RI	TA	PE	REZ				J	Month ANUARY	13,	2004	6:15	A^M
	/Medic Examir		4a. Fecility Name (If not institution, giv	e street and number)			4b. City	, Town, or	Location of	Death		4c. C	ounty of Deel	th	
			ANNAPOLITAN ASSIS	STED LIVING	G		ANN	APOL:	IS			ANI	NE ARUI	NDEL	
	Funeral		Social Security Number 6. S		e (In yrs.	last birthday)		r 1 Year	If Under 2		B. Date of Birth	Voor)	9. Birt	thplace (State of	r Foreign
	Director		220-01-4397	I M 2 🖾 F		84 Yrs.	Months	Days	Hours	Min.	(Month, Day, JLY 16.		_	YLAND	
	<u> </u>		Usuel Residence of Decedent										J 11111	THOMP	
	how		10a. State 10b. County	_		ty, Town or Lo	cation							10d. Inside Cit	
	a-f.s	cto	MARYLAND ANNE AR	UNDEL	A	RNOLD								1 🗌 Yes	2 ∑ No
	or 28	Director	10e. Street and Number				10f. Z	ip Code			1	0g. Citize	on of What Co	ountry?	
	th wil		821 MAC SHERRY DR	IVE			2	1012				UNIT	ED STA	TES	
	dea	Funeral	11. Marital Status	12. Was Decedent B Armed Forces?	Ever in U	.S. 13.	Was Dece	edent of Hi	ispanic Origi	in? (Speci	fy Yes or No- can, etc.)		Rece - Ame	rican Indian,	
9	or Ite	Ē	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2X N	No	į				rueito ni	can, etc.)		Black, Whit		
င္တ	ral'.	ğ	3√∑ Widowed 4 □ Divorced	Year or Dates:			1 🗌 Yes	₩ NO	Specify:			3	Specify: W	HITE	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show int, Ite Madical Examinat must be notified at	Completed by	15. Decedent's E			16a. Dece	dent's Usu	ual Occupa	ation	of working		16b. Kind	of Business/	Industry	
7	thin	du	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life.	DO NOT	use retired	during most o						
	er th	S	8			HOME	MAKE:	R					N HOME		
밀	be file	Be	17. Father's Name (First, Middle, Last,						18. Mother:	's Name (First, Middle, M	Maiden S	umame)		
<u>a</u>	should to and Ment marked umatics	၉	JOSEPH SZCZUBLEWS	KI					JULIA	A O'E	BRIEN				
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-1 show apprintury or other traumatic svent, Itie Madical Examinating must be notified at an once.	9 5	19a. Informant's Name/Relationship (Route Number,	City or	Town, State, 2	Zip Code)	
	and salth n 27	Κ.,	JOYCE D. HUNTER -	DAUGHTER					DRIVE	E AF	RNOLD,	MARY	LAND	21012	
Baltimore,	of He		20a. Method of Disposition 1 Burial 2 Scemation 3	Bomougl from State	20b. F	Place of Dispo semetery, crer	sition (Na matory or	me of other place	e) JAI	NUARY	16.	20c. Loca	ation - City or	Town, State	
Ĕ	Pages nent of int; if it		'4 □Donation 5 □ Other (Specif	y)		AR HIL			1	2004		ROOK	LYN PK	, MARYL	AND
<u>=</u>	permit. Departn Importa any inju	l Y	21. Signature of Furreral Service Licer	1See	100	22	2. Name a	nd Addres	s of Facility	CESTIC.				21061	
m	Depa Impo Any ii		- Callwy			42	I CE	XIN H	DICK I	FUNE Y S.E	AL HOM	F Bů	A RNIE, I	MARYLAN	D
ş			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the deat	h. Do not ent	er the mo	de of dying	g, such as ca	ardiac or i	espiratory arre			Approximate	9
	Physician		Immediate Cause (Final	CALA	0 .	Lin 1	200	L	C. C.					Interval Betw Onset and D	leath
	/Medical		disease or condition resulting in death)	a. Due to (or as	Consen	neuce of):	Te de	<u>u -</u>	au	ve_				many 4	lean
	Examiner			. Ph	. /	2 2 1	11	- 1					ĺ	man 6	1cen
5	, <u> </u>	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a		uence of):	>00 11	CHO	<u> </u>						1
	be executed sician and burial-transit	Examiner	Cause (Disease or injury	D	e me	ntio								many ye	m,
~	n an ial-tr	Exa	resulting in death) Last	Due to (or as											
760,	te be executed ysician and te burial-transit	call		a Cere	boro	vascu	cleur	Or	cci d	lent-	-			inny	yen
89				, u											
Вох	leath certificat attending phy I for use as thi	M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								23	d. Date of deli	verv	
m	leath atte	cla	in the past 12 months? 1 □ Yes 2 ☑No	1 ☐ Live birth 4 ☐ Pregnant at			JEctopic p Other (s	regnancy pecify)					Month	,	ear
o.	that the de ed by the a detached f	Physiclan/Med	9 Unknown	9□ Unknown											
σ.	The law requires that the death certifica tie has been signed by the attending ph page 2 should be detached for use as th	by PI	Part II. Other significant conditions of	ontributing to death bu	ut not res	ulting in the u	nderlying	cause give	n in Part I.		23e. Did tob	acco use	contribute to	the cause of de	ath?
Records,	uireg Sign										1 ☐ Ye	s 2123	No 3∏Pro	obably 4 🗆 U	nknown
င္ပ	w require been sig	Completed									24a. Was ar		24h Wara au	topou findings o	volabla
Be .	ne law s has ge 2 s	E D								_	autopsy	/	prior to death?	topsy findings a completion of ca	use of
			06 14/								1 ☐ Yes 2	No	1 🗆 Yes	2 🗆 No	
Vital	Physicien: The ribis certificate har al director, page	o Be	25. Was case referred to medical examiner?	Hospital:		55.0		OA Othe			Chack only one			ALF	-
ō	Phys rthis raldi	-	1 ☐ Yes 2 ☒ No 27. Manner of Death	1 Inpatier		ER/Outpatien 28b. Time of		04	4 🔲 IVUIS		5 Reside		-	SSISTED	LIV)
U C	ding I h. After funer	tlon	1 Natural 5 ☐ Pending	(Month, Day	(Year)	Injury	м	28c. Injury Work	:?` ∕es 2∐No		o. 20001130 110	v injury (,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
S	Attending r death. sctor: After by the funer	ica	3 ☐ Suicide 6 ☐ Could not b	8 20 01 (1)	IDV - At ho	ome form etc					Location /Str	not and I	Vumbor or Pu	ral Route Numb	
Division of	l or Attendater death Director: In by the	Certification:	4 Homicide determined	building, etc	. (Specifi	y)	eel, lactor	y, once		201	City or Town	State)	vuinber or Au	rai moute ivumb	Θ/,
hand .	Hospital or 24 hours afte Funeral Dir tely filled in		29a Certifier 1 ☐ Certifying Ph	ysicien: To the best of	of mu kno	wlodeo death			distribution of the second	NLC: CIL				7777	
F	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	(Check only 2 Medical Examone)	niner: On the basis of and manner sta	examina	tion and/or in	vestigation	n, in my op	ninion, death	occurred	at the time, da	te and p	ace, and due	to the cause(s)	
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	and manner sta			29	c. License	number		29	d Date	signed (Month	Day Year)	
	F 3 F 8		· Am	la		-	-		1051	9			3 -04	, , , , , , , , , , , , , , , , , , , ,	
	h		0001.		-				(0)	1			3 4		
			30. Name and address of person who		-				-1.	C. 0	0.	`	DINI	1	
			31. Date filed (Month, Day, Year)	Registra	5 0	AK WGO	D ('R	OF	31dg.	cele	u (Busn	u/	2106	1/-	
**	Sta Registr		JAN 1 4 200	4 Staries	J.	Asse	Sec. D								

			1 - For State Registrar	State of Maryland / D	Department of H Certificate of I		ntal Hygien Reg. N	_ / IIII lu	00665
	Physici /Medi		Decedent's Name (First, Middle, Last) Gorman	W. Reagan		1 6	Date of Death Month D	iD, 2004	3. Time of Death
	Examir Funeral Director		4a. Facility Name (If not institution, give s 5. Social Security Number 215-16-3484 6. Sex	heare 7. Age (In yrs. last birt	Baltin	Location of Death OF C If Under 24 Hrs. 8. Hours Min. De	Date of Birth (Month, Day, Yea	9. Birthpla County 921 Mary1	ace (State or Foreign ry) and
Ε,	D	_	Usual Residence of Decedent 10a. State 10b. County	10c. City, Towr					d. Inside City Limits
	h with the M 13a or 28a-f at be notilie	al Director	Maryland Baltimo 10e. Street and Number 4325 Ridge Avenue	ore Baltim	nore 10f. Zip Code 21227	 7		Citizen of What Count Inited Stat	ry?
36	irs after deal	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Ŷes, Give Year or Dates:	13. Was Decedent of Hilf Yes, specify Cuba	ispanic Origin? (Specify n, Mexican, Puerto Rica Specify:	Yes or No- an, etc.)	14. Race - America Black, White, et Specify: Wh	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iteme 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be routilled at ODGE.	Completed	15. Decedent's Edui (Specify only highest grade Elementary/Secondary (0-12)	cation 16a.	Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired	furing most of working)		Kind of Business/Indu	•
Maryland 2	uld be filed Mental Hygid srked other atic event, II	To Be Co	17. Father's Name (First, Middle, Last) Tulla Reagan	1	Agent Opera	18. Mother's Name <i>(Fi</i> Verdie Gor	irst, Middle, Maide	nessie Sys on Sumame)	tem
	I and 2 sho Health and I om 27 is me ther traums		19a. Informant's Name/Relationship (Ty) Wandalean K. Reaga	an - Wife 432	Mailing Address (Street a 25 Ridge Ave:	nue Baltin	more, Mar	yland 212	27
Baltimore,	iit. Pages artment of H ortant: If its injury or of		20a. Method of Disposition 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	emoval from State Meadow	y, crematory or other plac ridge Mem.	Pk. 1/14/0)3 Elk	Location - City or Tow Tridge, Man	ryland
Ba	permi Depa Impo any ir		23a. Part1. Enter the disease, or compli	cations that caused the death. Do n	1/250 Washi	is of Facility ufman Funer ngton Blvd. g, such as cardiac or re	EIKric	lge, Maryla	and 21075 Approximate
U)V	L notate be executed // Medical Examiner sthe burial-transit	Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. Lary, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	of):	es es es es es es es es es es es es es e	Disea	re i	Interval Between Onset and Death
P.O. Box 68760,	ath certifi ttending or use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of delivery Month D	y Vay Year
	w requires that the de been signed by the a should be detached t	ρ	Part II. Other significant conditions con	tributing to death but not resulting in	the underlying cause give	on in Part I.		use contribute to the	\ <
al Records,	hyelcian: The law re nis certificate has ber I director, page 2 shc	Completed					24a. Was an autopsy performed?	prior to comp death?	sy findings available pletion of cause of
X	reician s certifi director	To Be	25. Was case referred to medical examiner?	ospital: 1 ☐ Inpatient 2 ≥ ER/Out	patient 3□ DOA Othe	26. Place of Death (Cl		6 Other (Secrita)	_
Division of Vital	ending Physath. or: After thi		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury 28b. Ti	me of 28c. Injury jury Work		Describe how inju		
		Certification	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury · At home, fare building, etc. (Specify)			City or Town, Stat		
	To the Hospitel within 24 hours a To the Funerel I completely filled	edical	29a. Certifier 1, Certifying Phys (Check only one)	ician: To the best of my knowledge, ler: On the basis of examination and and manner stated.	death occurred at the tim For investigation, in my op	e, date and place, and inion, death occurred a	due to the cause(s t the time, date an	s) and manner as stated place, and due to the	ed. re cause(s)
ı	To t To tl	Ž	29b. Signature and title of certifier	mn	29c. License	4	L	ate signed (Month, Da	• • • • • • • • • • • • • • • • • • • •
	15 1		30. Name and address of person who con	mpleted cause of death (Item 23a) (7	Type, Print)	8.764 enve B	altination	- MARI	land
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	and i				

DHMH 17 Rev 1/2001

Reagan, Gorman

		1 - For State Registrar	State of Mar	yland	/ Departme				iene 19. No. 2004	00666
Physic	ian	Decedent's Name (First, Middle,	LASI) RAME	v				2. Date of Deat Month	h Day Yeer	3. Time of Death
/Med Exami		JANNEY 1 4a. Fecility Name (If not institution,		1	4b. C	ty, Town, or l	ocation of Deat	Januar	4c. County of Dee	
LXaiii	iici	Johns Hopkins	Bayview Med	ical (Centier (Baltir			N/A	1
Funera Director		5. Sociat Security Number 213-52-3176	7. Age (1 🕅 M 2 🗆 F 56		Yrs. tf Un Mont		Hours Min.	8. Date of Birth (Month, Day, May 14,	1947 West	thptace (State or Foreign ountry) t Virginia
put		Usuet Residence of Decedent 10a. State 10b. County		IOc. City	Town or Location					10d. Inside City Limits
illed within 72 hours after death with the Maryland Hygiene. Hygiene. Why a natural, or itams 23a or 28a-f show ont, the Medical Examiner mante notified at	tor	,	/A	ou. Ony,	Tom of Education	В	altimore	•		1 X Yes 2 □ No
ith the	Director	10e. Street and Number			10f.	Zip Code			0g. Citizen of What C	ountry?
s 23a	rail	1011 Highnet Way	12. Was Decedent Ev	or in II C	13 Was Da		205	Innaity Van as No.	U. S.	
fter de	Funeral	11. Marital Status 1 □ Never Married 2 🕅 Marrie	Armed Forces? d 1 ☐ Yes 2 X No			1/		pecify Yes or No- to Rican, etc.)	Btack, Whi	
ural', o	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:				Specify:			Vhite
in 72 h	Completed	15. Decedent's (Specify only highest	grade completed)		16a. Decedent's U (Give kind of life. DO NO	sual Occupat work done du Luse retired)	ion iring most of wo	rking	16b. Kind of Business	/Industry
d with giene	omo	Etementary/Secondary (0-12) 11th Grade	College (1-4or 5+)		Mec	hanic			Auto	
Lally railed with and Mental Hygiene. Is marked other the aumatic event, the	Be	17. Father's Name (First, Middle, La	ast)					me (First, Middle, I	Maiden Sumame)	
should nd Men marke	2	John Ramey 19a. Informant's Name/Relationshi	(Type Print)		19h Mailing Addr	ass (Stroot ar		ris Lamp	City or Town, State,	Zin Codel
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "nature any injury or other traumatic event, the Medical process.		Janney Makowski							ennsylvan	1
Pages 1 and of Head of		20a. Method of Disposition 1 X Buriat 2 ☐ Cremation		20b. Pla	ce of Disposition (i				20c. Location - City or	
permit. Pages 1 and 2 Department of Health Important: If Item 27 any injury or other tr		*4 □Donetion 5 □ Other (Spe	ecify)	Gard	dens of F				Baltimore,	
permit. Departrimportu		21. Signature of Funeral Service-Li	danis						Funeral Ho e, Maryla	
Physician		23a. Bent1. Enter the disease, or o chock, or heart failure. List	implications that caused the course on each line.	ne death.	Do not enter the n	node ot dying	, such as cardia	or respiratory arre	est,	Approximate Interval Between Onset and Death
/Medica		disease or condition resulting in death)	Due to (or as a	conseque	A					
Examine		Sequentially list conditions, if any, leading to immediate	b. Oue to (or as a	CONSEQUE		dial	Inta	rction		
uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
e be exec sician an e burial-tr	Exa	resulting in death) Last	Due to (or as a	conseque	nce of):					
icate b	dical	2	d							
ox occurifications use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 □ Live birth 2			pregnancy			23d. Date of de	livery
wrequires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown	4☐Pregnant at tii 9☐ Unknown						Month	Day Year
s that the	by Ph	Part II. Other significant condition	s contributing to death but	not result	ing in the underlyin	g cause give	n in Part I.	23e. Did tob	pacco use contribute t	o the cause of death?
require een sig								1 □ Y€	s 2 No 3 P	robably 4 Unknown
has by	Completed							24a. Was a autops perform	y prior to	utopsy findings available completion of cause of
ifficate or, page	60	25. Was case reterred to medical					26 Place of Dea	1 ☐ Yes 2	No 1 □ Ye	s 2 No
ysicie is cert direct	To B	examiner? 1 ☐ Yes 2 No	Hospital:	2 □ EI	R/Outpatient 3□	Othor	~		nce 6 Other (Spe	ecify)
ing Phy Mer this		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)		8b. Time of Injury	28c. Injury Work		28d. Describe ho	w injury occurred	
uttend death ctor: A	ficati	2 Accident Investigated 3 Suicide 6 Could not determine	t be 380 Ptage of Injury	v - At hom	M ne. tarm. street, fac	1	es 2 No	28f. Location (St.	reet and Number or F	ural Route Number.
tel or A safter s after all Dira	Certification:	4 Homicide	building, etc.	(Specify)		,,		City or Town		
To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit	edical	29a. Certifier 1X Certifying (Check only one)	Physicien: To the best of xaminer: On the basis of e and manner state	xaminatio	ledge, death occur on and/or investigat	red at the time ion, in my opi	nion, death occu	e, and due to the caurred at the time, da	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier	0		-	29c. License			9d. Date signed (Mon	th, Dey, Year)
1		Kame A.	Hangoth,	no		KES	000		January	9,2004
1		30. Name and address of person w		ath (Item 2	23a) (Type, Print)	Ca	la- L	1940 F	aston.	9, 2004 The Balt,
s	tate	Laura Hany 31. Date tiled (Month, Date 1991)	1 4 20 142. Registra	s Signatu	23a) (Type, Print) Modricas	and I	74	V 1 10 C	-4318W/	mD
Regis		UMIN .			-					21224

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** January 12, Rettman 2004 5:40 Anna B. /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore N/A Joseph Richey Hospice If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Dec. 19, 1922 Birthplace (State or Foreign
Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 🗓 F 81 Maryland 214-18-3252 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County rithsn "natural", or iteme 23a or 28a-f show the Modicel Examination must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21220 822 Cold Spring Road Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: ۵ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) e filed within 7 at Hygiene. Elementary/Secondary (0-12) 8th Grade College (1-4or 5+) Own Home Homemaker nd 2 should be filed with and Mental Hygie 27 is marked other fraumatic sysnt, it 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Zeller Ihle Frederick Maru 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2 s Department of Heelth an Important: If itsm 27 is any injury or other trau 1 and 2 s 17509 Prettyboy Dam Rd., Parkton, MD 21120 Mrs. Laura Rew (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Most Holy Redeemer 1/15/2004 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licensee 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Diogressive /Medical Due to (or as a consequence of): Examiner esoprovascular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner enfluent ascular use as the burial-tran Due to (or as a consequence of): Years IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 X No for 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. sete has been signed page 2 should be de Vital Records. 1 Yes 2 No 3 Probably 4 Unknown Rena Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22 No al No 1 Tes 1 ☐ Yes certificate or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No 2 ER/Outpatient 3□ DOA Medical Certification: To of 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death After Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No М death. investigation the hours after deat 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funeral I completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D24170 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N Eutaw St 838 Richey 31. Date filed (Month, Day, State Registrar

U

Lettman

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year HERBER **Physician** SteR 2001 01 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner 1A Medica ALtimoRe BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yeer) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplace (Stete or Foreign Country) **Funeral** Months 15 M 2□ F Director 213-14-5453 Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylend Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "naturel", or items 23s or 28s-f show any injury or other traumetic event, the Medical Examinal must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 X Yes 2 □ No Director MD BALTIMORE NΑ 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 153 21229 S. HILTON STREET USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No 1943 If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status AFRICAN 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 □ No Specify: Completed by 3 Widowed 4 Divorced Year or Dates: AMERICAN 1945 Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 0 LABORER FACTORY 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) HENRY ROYSTER EULA ROYSTER 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) HERBERT N. ROYSTER (SON) CRISFORD PLACE APT. J PIKESVILLE, MD 21208 20b. Place of Disposition (Name of cemetery, cremetery or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OWINGS MILLS, MD GARRISON FOREST VET. CEM. 1/20/04 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WYLIE FUNERAL HOME PA 638 N. GILMOR STREET BALTIMORE, MD 21217 Pent 1. Enter the disease or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physiclan/Medical Examiner veu Attending Physician: The law requires that the daath certificata be axecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pega 2 should be detached Yes 2□ No 3□ Probably 4□ Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' has 1 Yes 2 No 1 ☐ Yes 2 ☐ HO certificate funerel director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 3 Inpatient 3□ DOA 2 ER/Outpatient 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 1 Matural 5 Pending i Director: Af of in by the fu 1 Yes 2 No investigation 2 Accident 6 Could not be determined To the Hospital or Atter within 24 hours aftar des To the Funeral Director completaly filled in by th 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NO 31. Date filed (Month, Day, Year) JAN 1 4 32. Régistrar's Signature State Registrar

			4 12.	artment of Health and Me rtificate of Death	Reg	g. No. ZUUL	00669
	Physici		1. Decedent's Name (First, Middle, Last) Lester	Stufft	2. Date of Death Month	Day Year	3. Time of Death 4 5:09 PM
	/Medid Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	January	4c. County of Dea	
			Johns Hookins Bayview Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Baltimore If Under 1 Year If Under 24 Hrs.		N/A	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Months Days Hours Min.	8. Date of Birth (Month, Day,) Feb. 5,	1917 9. Bi	rthplace (State or Foreign ountry)
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L		<u>-</u>	PA	10d. Inside City Limits
	Maryli Ff sho	tor	MD Baltimore Balti				1 ☐ Yes 2√ No
	or 288	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What C	ountry?
	s 23a	eral	10235 Bird River Rd 11. Marital Status 12. Was Decedent Ever in U.S. 13.	21220		USA	
9	after de or Item niner	by Funeral	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No	Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto R	lican, etc.)	14. Race - Am Black, Whi	
215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-1 show he Medical Evaminar must be rotified at	d by	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ᠓ No Specify:			
215-	nin 72 in "nat	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation a kind of work done during most of working DO NOT use retired)	g 16	6b. Kind of Business	/Industry
2	ed with ygiene ner tha	Com	8th Mil	lwright		Bethlehem	Steel
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. tiem 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Evantiner must be retilised at	o Be	17. Father's Name (First, Middle, Last) Jacob B. Stufft	18. Mother's Name (aiden Sumame)	
aryl	2 shoul and Me Is mark	ပ		ng Address (Street and Number or Rural		City or Town, State,	Zip Code)
	1 and 2 Health em 27 I		Donald Stufft/Son. 10237 20a. Method of Disposition 20b. Place of Disp	Bird River Rd., Bo			220
nor	Pages nent of H int: If ite		1 ♥ Burial 2 □ Cremation 3 □ Removal from State 1 ♣ □ Donation 5 □ Other (Specify)	osition (Name of pattern) Solution (Name of pattern) Faith Cem. 1/15/20		oc. Location - City or Stimone.	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a any injury or other traumatic event, the Medical Evantment must bonce.			2. Name and Address of Facility Sch	imunek F	uneral Ho	mes
			23a Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	9705 Belair Road, I ter the mode of dying, such as cardiac or			Approximate
	Physician		Immediate Cause (Final disease or condition Respiratory F	ailure			Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence of): Pulumonia	torform			
		ner	if any, leading to immediate Due to (or as a consequence of):				
	ecuted and I-transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				1
8760,	The law requires that the death certificate be executed tte has been signed by the attending physician and page 2 should be detached for use as the burial-transit		d				
9	ndificate ng phys s as the	Medi	IF FEMALE:				
Вох	eath certifi attending for use as	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	Ectopic pregnancy Other (specify)		23d. Date of de Month	livery Day Year
P.O.	that the de ned by the detached	hysic	1 Yes 2 No 4 Fregnant at time of death 51 9 Unknown 9 Unknown	J Other (specify)			
	res tha signed be det	by	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.			the cause of death?
corc	w require been si should t	leted			1 Yes 24a. Was an		obably 4 Unknown
Vital Records,	The lavate has page 2	Completed			autopsy performe	prior to	Itopsy findings available completion of cause of 2. No
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (7110	4 2.110
of	Phys this ral dii	.: To	1 ☐ Yes 2 No Hospital: 1 Alinpatient 2 ☐ ER/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time of		e 5 Residence d. Describe how	e 6 □Other (Spe	city)
ion	Attending I ir death. ector: After by the funer	atlor	1. Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accidentinvestigation	f 28c, Injury at Work? M 1 ☐ Yes 2 ☐ No		,,	
Division	al or Atte	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	eet, factory, office 28	f. Location (Stree City or Town, S	et and Number or Ru State)	ural Route Number,
۷ .	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical (29a. Certifier (Check only one) La Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, an vestigation, in my opinion, death occurred	d due to the caus I at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Ň	29b. Signature and title of certifier	29c. License number		. Date signed (Mont	
	5	-	30. Name and address of person who completed cause of death (Item 23a) (Type,	AF-2664200-6	= 337 Va	anuary 11	2004
_			4940 Eastern Avenue Baltimor	e, MD 21224		•	
	Sta Registr		4940 Eustern Avenue Baltimor 31. Date filed (Month, Day, Year) 1 4 2004 Baltimor	Sparte			

State of Maryland / Department of Health and Mental Hygiene 🤈 00670 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month VIRGIL **Physician** 540A M SCHUSTER JANUARY 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Baltimore Augsburg Lutheran Home 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral ™** M 2□ F 214-14-4893 94 1909 Director Kansas Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23s or 28s-1 show ury or other traumatic event, the Medical Examinat must be neithfied at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Baltimore Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6811 Campfield Road 21207 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ⊋Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done duri life. DO NOT use retired) ng most of working Elementary/Secondary (0-12) College (1-4or 5+) Esskay Meats 12 Esskay Meats 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mahlon Schuster Dora Pingle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred Schuster - Wife 6811 Campfield Road Baltimore, Maryland 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If eny injury or pace. 4,□Donation 5 □Other (Specify) Meadowridge Mem. Park 1/12/04 Elkridge, Maryland 21. ignature o Funera Service Licensee 22. Name and Address of Facility Bradley Ashton Matthews Funeral Home, Inc. 2134 Willow Spring Road Dundalk, Maryland 21222 (23a Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Dacteria disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed anding physician and use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) the 1 Yes 2 No 9 Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2-No 3 Probably 4 Unknown should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has t autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖽 No 2 28a. Date of Injury (Month, Day Year) funeral 28h Time of 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 1 🖪 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death Director: / d in by the f 2 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours aff To the Funeral Di completely filled in TCCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) 737573 400216 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Reisteston 21136 12/00/15 75 Mari MD Jos 32. Segistrar's Signature 31. Date filed (Month, Day, Year) State JAN 1 4 2004 Registrar

		1	For State Registrar	State of M	Marylar	nd / Depa <i>Cei</i>	artment o	f Health a of Death	and Mental	Hygien		+ 0067
		1	. Decedent's Name (First, Middle, Las	it)					2. Date of	of Death		3. Time of Death
Phys /Me	ician dical	ı	Doris Margaret So	wer					Jan.	10		
	niner	4:	a. Facility Name (If not institution, give	street and numbe	or)		4b. City, Tow	n, or Location of	of Death	40	. County of Dea	
	۲.	_	Stella Maris Hosp				Timo		0410		Baltim	
Funer Direct			Social Security Number 6. S 212-03-1876 Sual Residence of Decedent	9X	Age (In yrs. 82	last birthday) Yrs.	If Under 1 Ye Months Da	ear If Under lys Hours	Min. 8. Date of (Month) December	of Birth h, Day, Year ber 21	, 1921	rthplece (State or Foreig ountry) Md •
land		-	0a. State 10b. County		10c. Ci	ty, Town or Lo	ocation					10d. Inside City Limits
5-0036 72 hours after death with the Maryland natural; or Itama 23e or 28e-f show lisal Examinat from critisis at	ģ		MD Baltimo	110		Perru	Hall					1 Tes 2 No
h the	<u> </u>	1	0e. Street and Number			Octy	10f. Zip Coo	ie		10g. C	itizen of What C	ountry?
th wit 23a o	by Funeral Director		4305 Piney Park	Road			21	128		u	SA	
ams ams	Iner	1	1. Marital Status	12. Was Decede Armed Force	nt Ever in U s?	J.S. 13.	Was Decedent If Yes, specify (of Hispanic Ori Cuban, Mexican	igin? (Specify Yes o	or No-	14. Race - Am Black, Whi	
36 s afte	Y.		1 Never Married 2 Married	1 □ Yes 2 If Yes, Give			1 ☐ Yes 2 💢				Specify: Wh	ite
hour tural	pe pe	-	3√√Widowed 4 □ Divorced	Year or Date:	5:	162 Dece	dent's Usual Oc	cupation		165 1	(ind of Business	Andustry
21215-0036 sol within 72 hours at glene. at then "natural", or the Medical Exam.	Completed	L	(Specify only highest gra	de completed)	- \	(Give	kind of work do	one durina mos	t of working	160.1	(IIIO OI DUSIII033	unidustry
Vith vith repair	E O		Elementary/Secondary (0-12)	College (1-4d	or 5+)	Cash	ier				Retail	
other other	BeC	1	7. Father's Name (First, Middle, Last)					18. Mothe	er's Name (First, Mi	iddle, Maide		
Aenta Aenta riked	To E		Frank Jacob					Mar	igaret Swi	anson		
Baltimore, Maryland 21215-0036 permit. Peges 1 and 2 should be tiled within 72 hours atter death with the Marylan Depentanent of Health and Mental Hygiene. Important: If tien 27 is marked other than "natural; or Itams 23a or 28e-f show eny injury or other traumatic event, the Madical Examine must be notified at	ľ	4	9a. Informant's Name/Relationship (Margaret Rohrs/Do						er or Rural Route N Id, Perry			Zip Code) 1128
S 1 ar		2	0a. Method of Disposition		20b. I	Place of Dispo	sition (Name o	f place)	Date	20c. l.	ocation - City or	Town, State
Baltimore, sernit. Peges 1 at Department of Hea mportant: If item ny injury or othe			1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify		re		remator		/12/2004	Bal	timore.	Md.
alti mit. pertm ports y inju	ä	1	21. Signature of Funeral Service Liver	- Jac		22	2. Name and Ad	dress of Facilit	y Schimus	nek Fu	neral H	omes
m 88E 5	8000		A mue	2000 C	A	3 97	05 Bela	ir Road	i, Baltimo	ore, M	d. 212	36
Physicial Medic Examine Examine Examine pricion and prinal-transit	al	1	mmediate Cause (Final disease or condition esulting in death) Sequentially list conditions, fany, leading to immediate acuse (Disease or injury hat initiated events esulting in death) Last	b. Due to (or	as a consec	quence of):		д				
687 ificate g phys	Physician/Medical Ex		F FEMALE:	d	as a consec							
O. Bc. the death y the atter	ysiclan		23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	1 Live birth 4 Pregnant 9 Unknown	2 ☐ Feta at time of a	aldeath 3	Ectopic pregna Other (specify				23d. Date of de Month	Day Year
T 2 2 9	b	۱ '	art II. Other significant conditions o	ontributing to death	n but not res	sulting in the u	nderlying cause	given in Part I		Did tobacco 1 ☐ Yes 2		o the cause of death?
Receiaw in the second s	Completed								:	Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
of Vital F Physician: Th this certificate ral director, pag	Be		25. Was case referred to medical examiner?					26. Place	of Death (Check of			
	2		1 ☐ Yes 2 ☐ No			ER/Outpatier	IL 30 DOA					HOSPICE
Jing After	ation;	2	27. Manner of Death 1 Manner of Death 5	28a. Date of li (Month, i	njury Da <i>y Year)</i>	28b. Time o Injury	4	njuryat Work? 1 ∐ Yes 2 🗍		ribe how inju	ry occurred	
Division To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification;		3 Suicide 6 Could not b 4 Homicide determined	280. Place of	Injury - At h etc. (Speci	ome, farm, sti fy)	reet, factory, off	ice	28f. Locati City o	ion (Street a r Town, Stat	nd Number or R e)	ural Route Number,
Hospit 24 hour. Funeral etely fille	edical (29a. Certifier (Check only one) 1 Certifying Ph	ysician: To the be niner: On the basis and manner	s of examina	owledge, deat ation and/or in	h occurred at th vestigation, in r	e time, date an ny opinion, dea	nd place, and due to ath occurred at the t	the cause(s ime, date an	and manner a d place, and du	s stated. e to the cause(s)
Го the	Me	1	29b. Signature and title of certifier				29c. Lic	ense number		29d. Da	ite signed (Mon	th, Day, Year)
				/0-			D	4372			1/12	104
٢	y	:	80. Name and address of person who						avrine	01000	., ,	
	2/4		DR. TARIO MAHM(OD 2300		NEY VA	LLEY RD	. TIMO	NIUM, MD	21093		
	State istrar		JAN	1 4 ZUU4	100	ر معلاہ	S. And	and I				

DHMH 17 Rev 1/2001

JANUARY 10, 2004 1:00 a.m.

DORIS SAUER

State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2004 HI nonna /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HOU If Under 24 Hrs. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Days 3 Yrs Director Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23s or 28s-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Heatth and Mental Hygiene. and them to thems 23a or 28a-1 show ant: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show ury or othar traumatic svent, the Medical Examiner must be notified at 1 ☐ Yes 2 No Be Completed by Funeral Director MORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white 3 ☐ Widowed 4 ☐ Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) JOHNS HOPKINS HOSPITAL 12. (0 TITIONER Eather's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 19a. Informant's Name/Relationship (Type, Print) Shand 50 (8 Spring) 9 osedale MC 20a. Method of Disposition
1 Burial 2 ☐ Cremation Date 20c. Location - City or Town, State 3 Removal from State permit. Page Department of Important: If any injury or once. -14-04 4 □Donation 5 □ Other (Specify) Unionlenuter 22. Name and Address of Facility ALTIMORE MD 21234 21. Signature of Funeral Service Mensee EVANS FUNERALCHAPEL 8880 HARFORD Part1. Enter the disease or complications that caused the shock, or hear failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** panereas metastanc 12003 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Completed by Physician/Medical IF FEMALE: 23c. If wes, outcome of pregnancy 12 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy as certificate has been signed by the atterdirector, page 2 should be detached for in the past 12 months? 1 Dayes 2 □ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 0 No 1 🗌 Yes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? Yes 2/2 No 1 Yes 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 1 Tes 1 🗌 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending investigation death. 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifie 29c. License number 053070 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1650 Orleans St Baltimar, MD 2123 John Hokin Hopital 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month **Physician** Eleonora Blanca Szerszen January 12, 7:00 P M 2004 /Medical 4e. Fecility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death **Examiner** Baltimore Manor Care Nursing Home - Rossville Rossville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplaca (State or Foreign Country) Poland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Yeer) Jan. 20, 1925 **Funeral** 1 □ M 2 ☑ F 78 214-30-6995 Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Baltimore Direct 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zip Code U.S.A. 21234 106 Hapsburg Ct. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status 1 Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify: þ Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien. Importants: if Item 27 is marked other the eny injury or other traumatic event, Insignate. Homemaker 12th Grade Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Salomea (Surname Unknown) Leon Hutter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr. Theodore Szerszen (husband) 106 Hapsburg Ct., Baltimore, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/14/2004 Baltimore, Maryland Bayview Crematory * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Cicensee 9705 Belair Rd., Baltimore, MD 21236 23a. Pert1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** HYSOKIA /Medical HOURS Due to (or as a consequence of): **Examiner** PNEUMO NIA Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of). Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ NO Month Dav Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? MZHEIMERS DEMENTIA 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death?
 1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) Director: After th 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🔲 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Postifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D55306 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rossmile Stoff are 122 force for Luis 203 DENNIE H. CONE MO MD 21237 31. Date filed (Month, Day, Year) JAN 1 4 32. Resistrar's Signature Registrar

RIGNERA

		1 = For State Registrar	•	epartment of Health and Certificate of Death	Mental Hygiene Reg. No	2004 00074
Phys		1. Decedent's Name (First, Middle, Last)	Smoot		2. Date of Death Month Day	Year 930 pm
	dical niner	4a. Facility Name (If not institution, give stre	et and number) Street	4b. City, Town, or Location of Deal	h 4c.	Country of Deeth Baltimyre,
Funer		5. Social Security Number 6. Sex	7. Age (In yrs. last birth	Months Davs Hours Min		9. Birthplace (State or Foreign Country)
ō		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location		10d. tnside City Limits
death with the Maryland me 23e or 28a-f show frust be notified at	Funeral Director	10e. Street and Number	ore B	OHIMORE 101. Zip Code	10g. Cit	1 ☐ Yes 227No izen of What Country?
ath with 23e or	rai Di	124 Edgewood	Street	21229		USA
Dallimore, Marylatin ZIZIS-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Toparament of Health and Mental Hygiene. Toparament of the article and their then. "naturat", or theme 23e or 28e-f show any injury or other traumatic event, the Modical Examinational toparament.	by Fune	11. Marital Status 12 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No life, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer 1 Yes 2 No Specify:	opecify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: PIAK
72 hou natura	eted	15. Decedent's Educal (Specify only highest grade of	ion 16a. D	Decedent's Usual Occupation Give kind of work done during most of wo life. DO NOT use retired)		ind of Business/Industry
ad within giene.	Completed	Elementary/Secondary (0-12) 12-10 CRADE φ	Cottege (1-4or 5+)	Teacher	E	Education
VICTOR VICTOR	To Be	17. Father's Name (First, Middle, Last)	•	18. Mother's Na Elizo	me (First, Middle, Maiden	Sumame)
Mary Mary Mary Mary Mary Mary Mary Mary		19a. Informant's Name/Relationship (Type	Print) 196. !	Mailing Address (Street and Number or R	ural Route Number, City of	or Town, State, Zip Code)
tore,		20a. Method of Disposition 1 Buriat 2 Cremation 3 Rem	cemetery	Disposition (Name of crematory or other place)	Ι	ocation - City or Town, State
rmit. Pages partment of portent: If it	DUCE.	21. Signature of Funeral Service Licensee	AD.	22. Name and Address of Facility	ughn CG	ings Mills, MD
0 8855	а	23a. Part1. Enter the disease, or complica shock, or hear tarlure. List only one	tions that caused the death. Do no	551 Botto, Not 1 P	c or respiratory arrest,	NOTE, MD 21229 Approximate Interval Between
Physicia		shock, or heart after List only one Immediate Cause (Final disease or condition resulting in death)	3	ELL CARCING		Onset and Death M < 5
/Medica Examine			Due to (or as a consequence of):		
uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to (or as a consequence of):		
icate be executed physicien and site burial-transit	ai Exa	resulting in death) Last	Due to (or as a consequence of):		
ontificate ing physes as the	Medicai	tF FEMALE:				
necolds, r.O. box of the law requires that the death certificate has been signed by the attending lage 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	If yes, outcome of pregnancy Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
w requires that the sear signed by should be detailed.	۵	Part II. Other significant conditions contin	buting to death but not resulting in t	the underlying cause given in Part I.		use contribute to the cause of death? ☑No 3 ☐ Probably 4 ☐Unknown
I KECORGS The law requires ate has been sign page 2 should be	1 12				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
Or Vital r Physician: Th rthis certificate ral director, pag	BeC	25. Was case referred to medical examiner?	spitat:	Other	ath (Check only one)	
n Or ng Phys fter this neral di	on: To	1 162 2 NO	28a. Date of Injury 28b. Til	me of ury 28c. Injury at Work?	dome 5 Residence 28d. Describe how injur	
DIVISION I or Attending after death. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of trijury - At home, farr building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No	28f. Location (Street an City or Town, State	id Number or Rural Route Number,
DIVISION OF To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	al Cer		ien: To the best of my knowledge,	death occurred at the time, date and place	e, and due to the cause(s)	and manner as stated.
thin 24 l	Medical	(Check only 2 Medicel Exemine one) 29b. Signature and title of certifier	r: On the basis of examination and and manner stated.	or investigation, in my opinion, death occ		te signed (Month, Day, Year)
5 7 £ 7		20	allegn, M.s	Do1786	JAM	1 09 2004
10		30. Name and address of person who com	pleted cause of death (Item 23a) (T	16 Maiden Choi	celane	Bacro, mas 1338
	State istrar	31. Date filed (Month, Day, Year)	pleted cause of death (Item 23a) (The state of the state	oords!		Bacro, Mas 1338

			1 - For State Registrar	State of M	Maryland / [-	artment of F		-	giene Reg. No.	2004	0067	15
-	Dhusisi		1. Decedent's Name (First, Middle,	Last)					2. Date of De	ath Day	Year	3. Time of Deat	h
*	Physici /Medic		EDWARD	Н.	S	TEF	FENHAGEN		JANUAR		2004	0100	М
	Examir	ier	4a. Facility Name (If not institution, g				4b. City, Town, o		th		County of Deer		
			ANNE ARUNDEL M				ANNAPOI				NNE ARU		
4	Funeral Director		081-24-0008	. Sex 7. /	Age (In yrs. last bir 73	rthday) Yrs.	If Under 1 Year Months Days	Hours Min		930	9. Bin Cc NE	thplace (State or Fore puntry) W YORK	эign
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	m or Lo	ocation		· · · · · · · · · · · · · · · · · · ·			10d. Inside City Lim	nits
	f aho	ō	NY		ELMS							1 ☐ Yes 2 📉	
	28a	Director	10e. Street and Number				10f. Zip Code			10g. Citiz	zen of What Co	puntry?	
	3a or	<u></u>	37 SOUTH HILLS	IDE AVENUE			10	523			S.A.	,	
36	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or Items 23e or 28e-f ahow imatic event, it a Medical Exertinal transitional inclination.	by Funeral	11. Marital Status 1 □ Never Married 3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Force 1 ☐ Yes 2 1 If Yes, Give Year or Dates	s? Wo		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes Ž∭No		Specify Yes or No to Rican, etc.))- 1	4. Race - Ame Black, Whit Specify: WH	e, etc.	
9	tural	edt	15. Decedent's			. Dece	dent's Usual Occup	ation		16h Kir	nd of Business/	Industry	
Maryland 21215-0036	within 72 iene. than "na It e Medic	Completed	(Specify only highest Elementary/Secondary (0-12)			(Give life.	kind of work done of DO NOT use retired NAGER	during most of wa	rking	AT8		industry	
and	d be filed ental Hygis ked other c event, II	To Be C	17. Father's Name (First, Middle, La ALBERT C. STEF			-			me (First, Middle,		Sumame)		
Ž	should ind Men inarke umatic	1	19a. Informant's Name/Relationship	(Type, Print)	19b	. Mailir	ng Address (Street	and Number or R	ural Route Numbe	er, City or	Town, State, 2	Zip Code)	
	1 and 2 Health a em 27 is		MARGARET WILLA	RD		37	SOUTH HII	LSIDE AV	JENUE, El	LMSF	ORD, NY	10523	
re,	ges 1 and 2 should t of Health and Men if item 27 is marke or othar traumatic		20a. Method of Disposition		20b. Place of	f Dispo	sition (Name of natory or other place	UNK	the same of the sa		cation - City or		
Ë	Pages nent of I int: If its iry or o		XXBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		(8)	-	HEAVEN CE			VAI	HALLA,	NY	
Baltimore,	permit. Pages Department of t Important: If ite any injury or of		21. Signatur of Fineral Service Line KELLY GREG	ORY FINK #	M01148		Name and Address	•	FINK F			Ī	
7	2.7		23a. Part1. Enter the disease, or co shock, or heart failure. Elst or	mulications that caus	ed the death. Do	not ent	er the mode of dyin	g, such as cardia	c or respiratory a	rrest,		Approximate Interval Between	
Size.	Physician		Immediate Cause (Final disease or condition	0	A	00	waten	Pa	cilla con	10		Onset and Death	
	/Medical		resulting in death)	Due to (or a	as a consequence	of.	<u> </u>	0	201101	16		0 VV [1] 1	L
स	Examiner		Sequentially list conditions,	b	1110	117	10/6	JC/G	-0515				
- 77	D #	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or a	as a consequence	of):	1	,					
1	ecute and trans	cam	Cause (Disease or injury that initiated events resulting in death) Last	C		-41							
	sate be executed physician and the burial-transit		,	Due to (61 a	as a consequence	OI):							
87	cate be executed physician and the burial-transit	dlcal		d									
9 X	ding p	/Me	IF FEMALE:	23c. If yes, outcome	ne of pregnancy								
O. Box	The law requires that the death certific lie has been signed by the attending p age 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1☐Live birth	2 Fetal death at time of death		Ectopic pregnancy Other (specify)			2	3d. Date of deli Month	very Day Year	
۵.	that the de led by the a detached t	P	Part II. Other significant conditions	s contributing to death	but not resulting in	n the u	nderlying cause givi	an in Part I.	23e. Did to	obacco us	se contribute to	the cause of death?	,
Records,	w requires tha been signed should be det	Completed by	<u> </u>				, , , , , , , , , , , , , , , , , , ,		101			obably 4 🗆 Unkno	
ě	has b	np(24a. Was autop	sy /	prior to d	topsy findings availa completion of cause (ble of
_	: The	So								rmed? 2 ☑ No	death? 1 ☐ Yes	2 🗆 No	
Vital	Physician: The la r this certificate has ral director, page 2	Be	25. Was case referred to medical examiner?	1					ath (Check only o	ne)			
	hysi this c	2	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpa				4 🗀 Nursing r	fome 5 ☐ Resid			cify)	
Ē	ing F After uner	on:	27. Mann of Death 1 ∠ Natural 5 ☐ Pending	28a. Date of In (Month, I		Time of njury	Worl		28d. Describe h	now injury	occurred		
Sic	Attending ir death. ector: After by the funer	cat	2 Accident investigat 3 Suicide 6 Could not	ha				Yes 2 □ No	006.1				
Division of	ital or Al rs after al Directed in Dy	Certification:	4 Homicide determine	building,	njury - At home, fa etc. (Specify)	irm, str	eet, factory, office		City or Tou	otreet and vn, State)	Number or Ru	ral Route Number,	
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier 1 Certifying (Check only one) 1 Medical Ex	Physician: To the besaminer: On the basis and manner.	of examination an	e, death d/or inv	n occurred at the time vestigation, in my op	e, date and place pinion, death occu	e, and due to the curred at the time,	cause(s) a date and	and manner as place, and due	stated. to the cause(s)	
	To t withi To t	Σ	29b. Signature and title of certifier	16 1			29c. License	number		29d. Date	signed (Month	Day, Year)	
			• W	Warrella	n Mi)	1	18443			////	(14	
	10		30. Name and address of person wh	o completed cause of	death (Item 23a)	(Туре,	Print)	Ann	und	M	31	(1))	
Ŷ	Sta	te	31. Date filed (Mpint) Day Year) 2	104 Regis	strar's Signature	1	1100	/ /1/1	14012	(111)		0/4	
	Registr	ar	07114 24	- Indiana	20	1	Section 1						

			For State Registrar AMFNI) TTFM 2				ertment of the tificate of			Reg. No.	04 0	0676
	Physicia	an	Decedent's Name (Fire	st, Middle, La	ist)	BORIS		SHUMA		2. Date of De	Day	Yeer	Time of Death 3:45 pm M
	/Medic Examin	al	4e. Facility Name (If not	EARL institution, gi	ve street and numb)		or Location of Death	JANUAE	4c. County		0.40 pm
	Examili	ei	GREATER BA	LTIMOR	E MEDICAI	CENT	ER	TOWSON			BALTI		
	Funeral Director		5. Social Security Number 215-28-171	13	Sex 7 1 M 2 □ F	Age (In yrs.	73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da NOV.18	3,1930	9. Birthplace Country)	(State or Foreign
	yland iow		Usual Residence of Dec 10a. State 10b	. County		10c. Cit	y, Town or Lo	cation					nside City Limits
	the Maryland r 28a-f show	ctor	MD	BALT	IMORE		BALTI						1 □ Yes 2 No
	vith th	Dire	10e. Street and Number	NOE C	TDOLE III	ITT 1		10f. Zip Code	01 000		10g. Citizen of V	•	. л
	death with ma 23a or	Funeral Director	23 STONEHI	INGE U	12. Was Deced	ent Ever in U	.S. 13. 1	Was Decedent of I	21208 Hispanic Origin? (Special, Mexican, Puerto	ecify Yes or No	o- 14. Rac	e - American I	A. ndian,
) 036	hours after d turel', or iten al Examinar	ρ	1 Never Married 3 Widowed 4 💢		Armed Ford 1 X Yes 2 If Yes, Give Year or Dat	□No		f Yes, specify Cub 1 □ Yes 2 🙀 No		Rican, etc.)	Specify	ck, White, etc.	WHITE
ECV 215-0036		Completed	(Specify or		ducation rade completed)		(Give	dent's Usual Occu kind of work done	during most of work	ing	16b. Kind of B	usiness/Indust	у
77 2	d within 72 giene. r then "nei the Medic	June	Elementary/Secondar	y (0-12)	College (1-4	for 5+)		DO NOT use retire RIETOR	Pa)		GUEST	HOUSE	
7 J	filed Hygi other	Be Co	17. Father's Name (First		t)		1 11011	CILION	18. Mother's Name	(First, Middle			
Z m	0 to 0	ToB	SAMUEL		В.		SHUMA	N.	LENA			ABRAMO	WITZ
MUWCN	12 should h and Mer 7 is marke traumatic	•	19a. Informant's Name/						t and Number or Rura				
E, N	and eath		MARVIN SHI		BROTHER	20b. F			ALLEY DRI	oate UV	20c. Location -		
ShuManBaltimore, Maryland	permit. Pages 1 Department of H Important: If ite any injury or otl		1 XBurial 2 □Cr	emation 3		tate OHF	emeraaro	sition (Name of patory or other pla	SRAEL 1/1	3/2004		TIMORE,	
altir	mit. P partme portan / injur		21. Signature of Funera			TOTIL			ess of Facility SOL				
ä	Ped Fig.		→ Selft	///	Wille		89	000 REIST	TERSTOWN R	0AD - F	PIKESVIL	LE, MD	21208
			23a. Part1. Enter the di shock, or heart fai	sease, or con lure. List on	mplications that ca y one cause on ea	used the deat ch line.	h. Do not ent	er the mode of dy	ing, such as cardiac o	or respiratory a	ırrest,	Apj Inte	proximate erval Between set and Death
	Physician /Medical		Immediate Cause (Fina disease or condition resulting in death)	il 1924	aC	inge	two	Went	frulu	~~		1	1 unter
68760,	icate be executed physician and sthe burial-transit	edical Examiner	Sequentially list condition if any, leading to immediate. Enter Undertyin Cause (Disease or injurthat initiated events resulting in death) Last	ons, diate g y	c	r as a conseq		ter Con	diovina	la d	ilu		They
Division of Vital Records, P.O. Box 6	Attending Physician: The law requires that the death certificat death. sector: After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as th	by Physiclan/Med	IF FEMALE: 23b. Was decedent pre in the past 12 mon 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	nths?		th 2 Feta nt at time of c	death 3	Ectopic pregnand Other (specify)	ey .			te of delivery onth Day	y Year
٥,	es that igned b	by Pt	Part II. Other significan		0 0 1		sulting in the u	nderlying cause g	ven in Part I.	23e. Did	tobacco use cont		
ord	w require been sig should b		Typ	VII.	denbil	5				1 🗆	Yes 2□No	3 Probably	4 Stanknown
ec	alawr hasbe e2sh	Completed								24a. Was	psy	Were autopsy prior to comple death?	findings available ition of cause of
al F	n: Thi ficate ir, pag		25. Was case referred t	to modical				-	Of Place of Death	1 ☐ Yes	2 No	1 ☐ Yes 2 ☐	l No
<u> </u>	hysician: The law his certificate has b I director, page 2 s	o Be	examiner? 1 Yes 2 No	to medical	Hospital: 1 Den	patient 2	ER/Outpatier	nt 3 DOA Ot	26. Place of Death ther: 4 \(\sum \) Nursing Ho		idence 6 ⊡Oth	er (Specity)	
J Of	ding Phy h. After thi funeral o	n: T	27. Manner of Death	Pending	28a. Date of		28b. Time o		ury at ork?	28d. Describe	how injury occur	red	
siol	Attendir death. ctor: Al y the fu	Certification:	2 🖸 Accident	investigati	ho -	-			Yes 2 □No	29f Location	Street and Numb	ar or Dural Da	uto Number
) į	or At after d Direct in by	ertifi	4 Homicide	determine	286. Place	g, etc. <i>(Speci</i>	ome, tarm, sti	eet, factory, office			wn, State)	er or Hural Ho	ute ivamber,
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the								ime, date and place,				
L	he Ho in 24 I he Fu pletel	Medical	one)		and mann		ation and/or in		opinion, death occur	ed at the time,			
	With To I	Σ	29b. Signature and title	of certifier	7 1/2	000	mo		6394		29d. Date signe		
			/. // //	. (1 /		u	P (()	100	6 5 7 7		7,111	- /	,
	di		20 Name and address	ر الله	o completed and	of death (lta	m 23a) /Tunn	Print)	,				UZUL
	t		30. Name and address	of person wh	o completed cause	Of death (Ite	m 23a) (Type,	Print) 69 /	V CHAR	レビジ	Sti	3mr	MI
•	Sta	ate	30. Name and address O W M 31. Date filed (Month, D	0	The) N (Print) 69 /	V CHAR	レニュ	Hill Str	3 Ar	MI
•		rar	DONIS	0	The	GLE) N (Print) 9 /	V CHAR	レニュ	Sti	3Ar	1204)

			riease Type of					-		
			For State C	of Maryland			lealth and M	ientai Hygi	lene 2001.	00677
			Registrar		Ce	rtificate of	Death	2. Date of Deatl	g. No. 🔄 🔾 🖂	00011
	Physicia	ın	1. Decedent's Name (First, Middle, Last)	CHAD	N EC	COLO	MON	Month	Day Year	3. Time of Death
	/Medic	al .	MAURICE	CHAR	(LE2	SOLO		JANUARY	11, 2004 4c. County of Deeti	12:12 A M
	Examine	er	4e. Facility Name (If not institution, give street and nu		CENTE		Location of Death		,	
4	Europel		HOSPICE OF BALTIMORE GI 5. Social Security Number 6. Sex	7. Age (In yrs. la			If Under 24 Hrs.	8. Date of Birth	BALTIMOI 9. Birth	nplace (Stete or Foreign
83	Funeral Director		215-10-8175 1XM 2CIF	91	Yrs.	Months Days	Hours Min.	8. Date of Birth Month, Day, FEB. 28,	1912	MD
	-24		Usual Residence of Decedent							
, \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\	show	No.	10a. State 10b. County	10c. City,	, Town or L					10d. Inside City Limits
42	Ba-fa	cto	MD BALTIMORE		OWIN	GS MILLS				1 □Yes 2 No
87	vith th	Director	10e. Street and Number			10f. Zip Code	04447	10	og. Citizen of What Co	ŕ
January 11,200	ous atter death with the Maryland ral', or Items 23a or 28a-f show Exertirer mant be reciffied at	Funerai	4730 ATRIUM COURT	edent Ever in U.S	2 13	Was Decedent of H	21117	orty Vac or No	14. Race - Amer	U.S.A.
5	after de or Item ruiner	'n	Armed F	orces?	3.	If Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)	Black, White	
22.88	urs af		3 ☑ Widowed 4 ☐ Divorced Year or Divorced	2 X No ive Dates:		1 ☐ Yes 21 No	Specify:		Specify:	WHITE
30	within 72 hours ane. than "natural", re Medical Exe	Completed by	15. Decedent's Education (Specify only highest grade completed,		16a. Dece	dent's Usual Occup	ation during most of worki	na l	16b. Kind of Business/l	ndustry
7 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	thin 7	npie		(1-4or 5+)	lite.	DO NOT use retired	d)			
× 2	be filed within 72 ho tal Hygiene. d other than "natus svant, the Modical				OWN	EK			BRONSON NOV	ELIY CO.
₹ pi		Be	17. Father's Name (First, Middle, Last) LEO		SUI	OMON	18. Mother's Name	(First, Middle, N	Maiden Sumame)	BOWERS
Maryland 2	2 should be filed within and Mental Hygiene. Is marked other than aumatic event. It a Ma	은	19a. Informant's Name/Relationship (Type, Print)					I Pouto Number	City or Town, State, Z	
	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic		RHONA BRAVER / DAUGHTE	R		SWANHILL			E, MD 21208	
و لو	ges 1 and 2 t of Health If Item 27 or other tr		20a. Method of Disposition	20b. Pla	ace of Disp	osition (Name of			20c. Location - City or 1	
Maunte Baltimore.	00		1 X Burial 2 ☐ Cremation 3 ☐ Removal from 14 ☐ Donation 5 ☐ Other (Specify)	State		matory`or other plac MIINO -ADI T	NGTON 1/1	2/2004	BALTIMO	DE MD
3 =	permit. Pag Department Important: b sny injury o once.		21. Signature of Juneral Service Licensee	. 1		2. Name and Addres			SON & BROS.	
≥ ñ	Deg a mag		A State M. City	li	V.	8900 REIS	TERSTOWN	ROAD - F	PIKESVILLE.	MD 21208
			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the death.						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	_ 1	Ke					Onset and Death
	/Medical		resulting in death)	(or as a conseque						week-s
- 1	Examiner		Sequentially list conditions, b.							
	sit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	(or as a conseque	ence of):					
_	and I-tran	хап	that initiated events c	(or as a conseque	ence of):					
760.	be executed sicien and burial-transit	calE		,	, .					
587	icate phys		d							
Box 68	leath certificate b attending physic d for use as the b	Physician/Medi		utcome of pregnan		-			23d. Date of deliv	very
ă	death e atte d for	icia	in the past 12 months?	birth 2 ☐ Fetal on mant at time of dea		⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>	' 	·	Month	Day Year
0.0	that the de led by the a detached i	hys	9 ☐ Unknown 9 ☐ Unkr	iown						
ú			Part II. Other significant conditions contributing to o	1	-	inderlying cause give	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
rd	aquire en si ould t	ted	coronary artery	1. 26 436	-			1 🗆 Ye	s 2 No 3 Pro	babiy 4 □Unknown
e C	has be	pie	Atrial fibrillation					24a. Was an	prior to c	opsy findings available ompletion of cause of
<u> </u>	The I	Completed by						perform 1 ☐ Yes 2	ed? death?	
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?			100	26. Place of Death	(Check only one)	17
Ę	Physician: this certifice ral director, p	J.		Inpatient 2 E	ER/Outpatie		4 INDISHING FIOR	me 5 Resider		in (0=pie
'n	ding I	tlon	1 Natural 5 Pending (Mor	nth, Day Yeer)	Injury	Worl	y at k? Yes 2 □ No	28d. Describe ho	w injury occurred	,
Division of Vital Becords.	f or Attending after death. Director: After in by the fune	fica	3 Suicide 6 Could not be determined 28e. Plac	e of Injury - At hor	me, farm, st	reet, factory, office		28f. Location (Str	eet and Number or Ru	al Route Number.
D.	after after Dire	Certification;	4 Homicide determined build	ding, etc. (Specify))	,		City or Town,	, State)	
¥	To the Hospital or Attending Phwithin 24 hours after death. To the Funesal Director: After thi completely filled in by the funeral		29a. Certifier Certifying Physician: To th	e best of my know	vledge, deal	th occurred at the time	ne, date and place, a	and due to the ca	use(s) and manner as	stated.
	he Ho in 24 he Fu pletel	Medical	(Check only 2 Medical Examiner: On the lone) and man	nner stated.	ion and/or in	ivestigation, in my o	pinion, death occurre	ed at the time, da	ite and place, and due	to the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certifier	1		29c. Licens	e number	29	d. Date signed (Month	Dey, Year)
	, -		Il Huthany 16	My.	no	1943	<i></i>	`	JANUAY	11,207
	2		30. Name and address of person who completed cau		23a) (Type,	Print)	t. Bolt	r md	Date signed (Month) Jan Unry 21 20/	
	Sta	10		6701 Registrar's Signati	nte (white -	, . , , , , , , ,			
	Registra		JAN 1 4 2004	Eur Si	1 for	ade				

State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND ITEM 20b PER FH G827 1/14/04 Chertificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** MERWYN JANUARY 8,2004 1:35 P SCHULMAN /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 7506 SPRING LAKE DRIVE BETHESDA

If Under 1 Year | If Under 24 Hrs. | MONTGOMERY 8. Date of Birth (Month, Day, Year) OCT. 17 19 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 213-32-0828 Yrs. Director Usual Residence of Decedent 10a. State MD MONTGOMERY 10c. City, Town or Location BETHESDA 10d. Inside City Limits Show r than "natural", or items 23a or 28a-f show the Madical Examinar round by notified at 1 Yes 2 No Funeral Director 10g. Citizen of What Country? 10e. Street and Number 7506 SPRING LAKE DRIVE 10f. Zip Code 20817 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 (V)Yes 2 (No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: WHITE 1 - Yes 2 No Maryland 21215-0036 à 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 5+^{College (1-4or 5+)} Elementary/Secondary (0-12) and Mental Hygiene. CERTIFIED PUBLIC ACCOUNTANT US GOVERNMENT ies 1 and 2 should be filed vol Health and Mental Hygie of Health and Mental Hygie If item 27 is marked other to other traumatic event, In 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **SCHULMAN** HARRY HILDA FINE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3321 SOUTH STAFFORD STREET ARLINGTON, VA. 22206 MS. LEONORE MCINTYRE/NIECE Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1/12/2004 permit. Pages
Department of I
Important: If ite
sny injury or ot MOSPICE PROPERTY PROPERTY PLACE)
WOODMOOR HEBREW CONG. 1/11/2004 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BALTIMORE, MD. 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Services see /ayti 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear, failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARTERIO SCLEROTIC HEART DISEASE **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner ed by the attending physicien and detached for use as the burial-transit Due to (or as a consequence of): Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 1 Yes 2 No rector. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide within 24 hours a

To the Funerel I

completely filled pelli 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1.9.2004 D13548 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10801 LOCKWOOD DRIVE SILVER SPRING MOZO90 K. SARIN RAJINDRA 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 1 4 2004 Registra

		-	- For State Registrar Amend Item	State of Maryland	d/Depg rflCe	attnent/9fd/ rtificate of D	ρ≱lth_agd M Death		iene 2	004	00679
			Decedent's Name (First, Middle, Last)					2. Date of Deat Month	h Day	Year	3. Time of Death
	Physicia		Virginia			Tipton		Sanuary		2004	6:00 PM
	/Medic Examin		4a. Facility Name (If not institution, give si	reet and number)	16	4b. City, Town, or	Location of Death	1	4c. Count	y of Deeth	
			Johns Hookins Bau	Wiew Medical	Center	Bal	timore				
	Funeral Director		5. Social Security Number 6. Sex 405–16–8735	7. Age (In yrs. 83	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Dec. 15,	^{Year)} 1920	Cour	place (State or Foreign htry) CUCKY
	σ		Usuel Residence of Decedent	Lie	-					1.	Od. Inside City Limits
	uylar show		10a. State 10b. County		y, Town or Lo						1 Yes 2 □ No
	Ba-f s	5	Maryland		altimo			1	0g. Citizen of	M/hat Caus	
	with the	Dire	10e. Street and Number 2437 Wes 2447 Westport Street	stport Street		10f. Zip Code 21230)	'		ed Sta	
	s 23	erai	-	2 Was Decedent Ever in U.	S. 13.	Was Decedent of His		ecify Yes or No-		ice - Americ	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic avent, the Medical Exemple: must be notified at	by Funeral Director	1 Never Married 2XMarried 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates:		If Yes, specify Cubar 1 ☐ Yes 2X No	Specify:	Rican, etc.)		ack, White, ify: Whi	
21215-0036	72 hou	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occupa kind of work done d	uring most of worki	ng	16b. Kind of	Business/In	dustry
121	within lene. then	mpidu	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired) Dauce Proc			Hearr	Kirk	twood.
	filed v Hygie ther I		17. Father's Name (First, Middle, Last) —	unk -	PLC		18. Mother's Name	e (First, Middle, I			
Maryland	ould be filed within Mental Hygiene. arked other than attic avent, the Mentic avent.	To Be	Robert Thurston He				Georgia I				
ary	2 should and Men is marke		19a. Informant's Name/Relationship (Type			ng Address (Street a					
	1 and 2 Health a lam 27 is		Bonnie Tipton - Dav			Westport		Baltimor			
Baltimore,	0 0		20a. Method of Disposition 1 ◯XBurial 2 □ Cremation 3 □ Re 1 □ Donation 5 □ Other (Specify)		dowric	osition (Name of matory or other place Ige Mem. P	ark 1/11,	/04		lge, M	aryland
Balti	permit. Pag Department Important: I any injury o		21. Signature of Eneral Service Cense) Mo12	90 GE	2. Name and Addres 1ry L. Kau 250 Washin	s of Facility Ifman Fund Igton Blvo	eral Hom	e At M idge,	MP., Maryl	Inc. and 21075
	7 5		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the deat	h. Do not en	ter the mode of dying	g, such as cardiac o	or respiratory arre	est,		Approximate Interval Between
	Physician	ĺ	Immediate Cause (Final disease or condition	Hypoxia				N 2-2-		t	Onset and Death
	/Medical Examiner		resulting in death)	ue to (or as a conseq	uence of):	1 Pail	- 0				2.10.10.10
Y	_Xdiffill()	_	Sequentially list conditions,	Due to Gras a conseq	uence of):	rt tallu	re				ive years
	ted insit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Aortic:	Stor	10515				P	100 11000
Ć,	execu n and ial-tra	Еха	that initiated events resulting in death) Last	Due to (or as a conseq						1	vegens
8760,	ate be executed thysicien and the burial-transit	cal									
9	ntifica ng ph as th	Ved	IC CEMALE							1	
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2₽₹No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3	□Ectopic pregnancy □ Other (specify)				ate of delivi	ery Day Year
	s that ned b		Part II. Dther significant conditions con	tributing to death but not res	ulting in the u	inderlying cause give	en in Part I.	23e. Did tol	oacco use co		he cause of death?
rds	w requires (been signe should be	ed b	chronic obstru	ctive lung	alse	ise		1 🗆 Y	s 2 No	3 Prot	oably 4 □Unknown
Records,	ne law requ has been ge 2 shouk	Completed by	pulmonary hy	pertension	1			24a. Was a autops	y	. Were auto	opsy findings available impletion of cause of
H		Com		1				perform 1 ☐ Yes	ned? 2. X No	death? 1 ☐ Yes	2 🗆 No
Vital	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?				26. Place of Deat	h (Check only on	e)		
of \	Physic this o	2	1 Yes 2 No	. 74	ER/Outpatie		4 🗆 I varsing 1 io	me 5 Reside			(y)
n C	ling P	ion	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work	rat (? Yes 2 □ No	28d. Describe ho	ow injury occi	illed	
Division	death death stor: / the	licat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h	ome, farm, si					nber or Rura	al Route Number,
Οį	after after Direct	Certification:	4 Homicide determined	building, etc. (Specif	(y)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town	n, State)		
	To the Hospitel or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C		sician: To the best of my knoter: On the basis of examina and manner stated.							
	within To the	Me	29b. Signature and title of certifier			29c. License			9d. Date sign		
			Vinabeth	Menashen	Mil	D. DOC	5725	4 J	ANUR	ARY	8,2004
	1		30. Name and address of person who co		n 23a) (Type	D. DOC Print) HULLER +	110=1 =1	, 20	i.T 2 40 = 1	26-	NEO
12.0	1		ELIZABET DO MEN				91719CDT	C DN	-11109	- Ca) /	
· · · · · · · · · · · · · · · · · · ·	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signa	M. A	and I					
			JAN 1 & 200	4 January d	S FUE						

			i icase			nt of Health and		•	
			For Stata	State of Maryla	•	ite of Death		70114	00680
			Registrar 1. Decedent's Name (First, Middle, Las	*1	Certifica	ile of Dealif	Reg. N	0.	3. Time of Death
	Physici	an	S'Avial BOALL	11/ Tanul	1:000 10		Month Da	ay Year	6:30 PM
Y	/Medic		4a. Facility Name (If not institution, give	street and number	190K, JR.	y, Town, or Location of Deatl) / / 0	c. County of Deal	
1	Examin	er	F. 1/1: C	11	:T1/ 6	1 1		10 17.	MOKE
	Funeral		5. Social Security Number 6. Se	ARE HOSP		OSC JAIR er 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Year		thplace (State or Foreign buntry)
	Director		215-12-98/08 1	M 2□ F	8 Yrs. Month	B Days Hours Min.	JUYU 2 19	22 NO	Pul CAId
	D		Usual Residence of Decedent				1-10-17		- yi ronca
	arylar show	_	10a. State 10b. County	10c. C	City, Town or Location				10d. Inside City Limits
	Be-f	cto	MD Baltin	ore Pa	RKVILLE				1 Yes 2 No
	death with the Maryland ms 23a or 28e-f show rmust be notified at	Funeral Director	10e. Street and Number	1 1	10f. 2	ip Code	10g. C	itizen of What Co	ountry?
	s 23s	rai	8024 SCHPORA	er Avy.	10 140 140 1	21234		14. Race - Ame	niona Indian
	ltem Item	in in	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces? 1 X Yes 2 No	U.S. 13. Was Dec	edent of Hispanic Origin? (S ecify Cuban, Mexican, Puert	o Rican, etc.)	Black, Whit	e, etc.
36	hours after turel', or Ite	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates: ∤	1 ☐ Yes	20 Specify:		Specify: (N)	lute
5-0036	n 72 hours after death with the Marylan "neturel", or Items 23s or 28e-1 show edical Examiner must be notified at	ted	15. Decedent's Ed	ucation	16a Decedent's Us	ual Occupation	16b. I	Kind of Business/	/Industry
215	nin 7	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT	vork done during most of wor use retired)	king		1.1
21	lled wit lygiene her the	Completed	10		Selfe	moloyed	CC	RRPINT	l K
	be file tal Hy d oth	Be (17. Father's Name (First, Middle, Last)	/ (0	18 Mother's Nan	ne (First, Middle, Maide	n Sumame)	
yla	should be filed withir od Mental Hygiene. marked other than imatic event, toe M	2	CRVINI B LOI	williger)	R.	Unk	NRISC	011	
Maryland	2 g 2 3 9		19a, Informant's Name/Relationship (7	ype, Print)	19b. Mailing Addre	ss (Street and Number or Ru	ral Route Number, City	or Town, State, 2	Zip Code)
	s 1 and if Health item 27 other tr	1	CRVIN J. IRR	UILLIGER - SON	Place of Disposition (A	VIITOU AVY.	Date: 20c. L	44,1	10 21043
ŏ	ges 1 t of F if ite or ot		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	cemetery, crematory of	other place)	L /Le 20c. L	Location City or	rown, State
Baltimore,	permit. Page Department o Importent: If any injury or once.		'4 □Donation 8 □ Other (Specify	11/1/2	w Catheon	al CONO. 20	004 Da	LHIMORE	MD
Bal	Deparent Dep		21. Signature of Funeral Service Livin		22. Name	and Address of Facility	ians runer	e chap	212211
	46200		222 Part 1 Enter the disease or come	lications that caused the des	1 8 8 0 (ode of thing with as cardia	& Daving	DER MIN	Approximate
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	one cause on each line.	(out or dying, agon as cardiac	or respiratory arrest,		Interval 8etween Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. CARDIOY	ou mon A	RY FAILUR	E		
	Examiner			Due to (or as a conse	equence of):	RIOTA			
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	RANIA equence of):	BIEEZ			
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events						
oʻ	e be executed sician and burial-transit	Exa	resulting in death) Last	Due to (or as a conse	equence of):				
1760		cai		d					
68	leath certificat attending phy I for use as the	Med	IF FEMALE:						
Box	th ce tendi	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet		pregnancy		23d. Date of del	ivery Day Year
	e dea the at	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	death 5 Other	specify)		WOILI	Day 19ai
P.0	requires that the death een signed by the atter hould be detached for u		Part II. Other significant conditions co	atributing to death but not re	sulting in the underlying	cause given in Part I	23e Did tobacco	use contribute to	the cause of death?
ds,	signe signe d be d	l by	, att ii.	and the desire set for the	outing in the directlying	oddod gwar ii r dw ii			obably 4 Dunknown
Vital Records,		Completed							
3ec	The law te has b age 2 s	E E					24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of
a			or was a stand to a stand				1 ☐ Yes 2 ☐ A		2 No
<u> </u>	Physician: The law this certificate has be ral director, page 2 s) Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Hospital 25	☐ ER/Outpatient 3☐ I		th (Check only one) lome 5 ☐ Residence	S [] (0th == / (0 = =	-4.
ot	Phys r this sral di	. To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury at Work?	28d. Describe how inju		ciry)
on	tending leath.	ţ	1/□Matural 5 □ Pending 2 □ Accident investigation	(Month, Day Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No			
Division		ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, street, facto	pry, office	28f. Location (Street a. City or Town, Stat	nd Number or Ru	ıral Route Number,
Ö	s after s after al Dire	Certification:	TIOMINICO	building, etc. (Spec			Only of Town, Stat	5 /	
L	Hospitel		29a. Certifier 1 Certifying Phr (Check only 2 Medical Exam	rsician: To the best of my kr	nowledge, death occurre	d at the time, date and place	, and due to the cause(s	s) and manner as	stated.
4	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	Medical	one)	and manner stated.					``
	To To To To To To To To To To To To To T	2	29b. Signature and title of certifier	1		9c. License number	29d. Da	ate signed (Montl	n, Day, Year)
	1					KES 0000	/	-12-	2007
	V		30. Name and address of person who o	ompleted cause of death (Ite	em 23a) (Type, Print)	RES 0000	DIT	40 11	1 21127
		10	DR. SUSAN BROC 31. Date filed (Month, Day, Year)	9000 pp	ANKIIN S	QUARE UR.	DALLIMO	RE M	a 21231
	Sta Registi	-	JAN	4 2004 egistrar Sign	we to be	234			

DHMH 17 Rev 1/2001

TERWilligeR

ERVIN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Sta	ite of Maryla	•	tificate of	Death		Reg. No. 200	4 00681
	Physician /Medica			ALIC	ET	URNE	R	2. Date of Dea Month	ath Day Yea	3. Time of Death
)	Examine	de Capitia, Nama /// national		and number)	ING KO	ME	4b. City, Town, or Baltim	Location of Death		ath
	Funeral Director	5. Social Security Number 215-66-448			rs. last birthday) Yrs.	if Under 1 Year Months Days			9. B 2-09 HC	irthplace (State or Foreign Country) Ward, Co.
	show	Usual Residence of Decede 10a. State 10b. Co	ounty	10c.	City, Town or Loc			· · · · · · · · · · · · · · · · · · ·		10d. Inside City Limits
	or 28a-f	Md. 10e. Street and Number	N/A		Baltim	Ore 10f. Zip Code			10g. Citizen of What (tv Yes 2 □ No Country?
050	penint. Tages I and Saloud be lied within 72 hours arer dean with the Maryland Important; if item 27 is merited other than "natural; or items 23s or 28s-f show any injury or other traumetic event, the Madical Examinar must be notified at once. To Be Commisted by Financial Director	1429 Gibs 11. Marital Status 1□ Never Married 2□ 3√□ Widowed 4□ Divided	12. Wa Arn Married 1	Rd. s Decedent Ever in ned Forces? Yes 2 XNo es, Give ar or Dates:		2122 as Decedent of Yes, specify Cut ☐ Yes 2 XNo	Hispanic Origin? (S ban, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	USA 14. Race - Arr Black, Wh Specify: B	ite, etc.
21215-0020	ir than "natura the Madical E	15. Dec (Specify only in Elementary/Secondary (0-12)	edent's Educetion lighest grade comp	leted) lege (1-4or 5+)		nt's Usual Occu ind of work done O NOT use retire	pation during most of wor ad)	king	16b. Kind of Busines Home	s/Industry
and	ntal Hygenter of other of the Care of the	17. Father's Neme (First, Mi				<u>cinuitor</u>	18. Mother's Nar		Maiden Surname)	
Maryland	and Meni	James 19a. Informant's Name/Rela	Howard Itionship (Type, Pri	nt)	19b. Mailing	Address (Stree	Susi		oward r, City or Town, State,	Zip Code)
Baltimore, M	ent of Health ut; if item 27 i	Christine 20a. Method of Disposition XXXBurial 2 □ Crema 4 □ Donation 5 □ Oth		20b I from State	1429 D. Place of Disposicemetery, crema	tion (Name of story or other pla	ice)	Date	more, Md, 20c. Location - City o	r Town, State
Ralt	Departm importar any inju	21. Signature of Funeral Se	vice Licensee	∇	Es.	Name and Addre	others	Funeral	Ser,P.A.more,Md.	
	hysician /Medical :xaminer	23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	e, or complications List only one caus a	1		RAL	PNEUN		rest,	Approximate Interval Between Onset and Death
00/00,	g physician and as the bural-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	6		(or as a conseque					1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
0 Y		resulting in death) Last	d				<u> </u>			
֝֞֞֜֞֝֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	signed by the atter be detached for u					erlying cause gi			/	e to the cause of death? Probably 4 Unknown
VICAL DECOURS, F.O. DOX	ate has been signe page 2 should be c							24a. Was a perfor		Were autopsy findings available prior to completion of cause of death?
		25. Was case referred to me	dical				26 Pinos of Dog	th (Check only or		1 ☐ Yes 2 ☐ H0
Ing Physician:	를 들 C	1 Yes 2 No	ending	1 ☐ Inpatient 2 Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Inju Wo	ner: 4D Nursing H	ome 5□Reside	ence 6 Other (Spe ow injury occurred	acify)
or Attending Day	after death Director: in by the	2 Accident Int	vestigation ould not be stermined 28e.	Place of Injury - At building, etc. (Spe-	home, farm, stree cify)		165 2 140	28f. Location (Si City or Town	treet and Number or F n, State)	iural Route Number,
Hoenitei	n 24 hours Ne Funera pletely fille edical (ical Examiner: On	To the best of my ki the basis of exami I manner stated.	nowledge, death o nation and/or inve	ccurred at the til stigation, in my o	me, date and place, ppinion, death occur	and due to the c rred at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
Tothe	within To the comple	29b. Signature and title of ce	aifier scenthe	akuw	amo	29c. Licens	se number	2	9d. Date signed (Mon	th, Day, Year) ,09, 200 (j 2/20 [
	IX	30. Name end address of per	rson who completed	cause of death (It	em 23a) (Type, Pr 2 / · · · /	int) EUTAN	UST, S	UITE 40	7, MD	21201
	State Registrar	31. Date filed (Month, Day	W 1 4 200	32. Registrar's Sig	nature	Cook 1				

		•	For State Registrar	State o	f Maryland		artment of H		and M	ental Hy	gien Reg. N	/ 1	004	00	682
	Physici	an	1. Decedent's Name (First, Middle Esther	S.		Tio	rnan			2. Date of D Month	eath Da	ıy	Year	3. Time o	
	/Medic		4a. Facility Name (If not institution		mber)	116	4b. City, Town, or	1 ocation o		Januar	-	. County	004 of Death	11:25) a "
	Examin	er	Anne Arundel				Annapo		Dogui				Arun	do1	
-	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. Ia	st birthday)	If Under 1 Year	If Under 2		8. Date of B	irth		9. Birtho	lace (State	or Foreign
	Director		471-05-2960	1 □ M 2 🕅 F	94	Yrs.	Months Days	Hours	Min.	(Month, D			Cour Min	nesot <i>a</i>	ı
	pu ,		Usual Residence of Decedent		100 City	Town or Lo	- ation							04 15-14- 0	Sh. I Sanian
	anyla shov	2	MD Anne	Arunde1		Town or Lo								10d. Inside C	2 No
	the M	Director	10e. Street and Number	Alunder	A	nnapo	10f. Zip Code				10g C	itizen of M	Vhat Cour		
	with		800 Bestgate	Road #12	q		21401				10g. 0	USA	viiat ooui	my:	
	Jeath	Funeral	11. Marital Status	12. Was Dec	edent Ever in U.S	. 13.	Was Decedent of H		gin? (Spe	cify Yes or N	0-	14. Race		an Indian,	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "neturel", or items 23e or 28e-1 show other traumatic event, I'le Modical Examinations to Intilized at	by Fun	1 Never Married 2 Marr	ſf Yes, Gi			fYes, specify Cuba 1 □ Yes 2 ∑ No	n, Mexican Specify:	, Puerto I	Rican, etc.)		81ac Specify	k, White,	_{etc.} White	
ğ	2 hou	ted	15. Deceden	t's Education			dent's Usual Occup		a fa drie		16b. l	(ind of Bu	siness/In	dustry	
218	thin 7	Completed	Elementary/Secondary (0-12)	st grade completed) College (1-4or 5+)	life.	kind of work done on DO NOT use retired	duning mosi f)	OF WORK	ig					
2	ed wi	8		4		Regi	stered Nu					Medi			
pu	be fill d oth	Be	17. Father's Name (First, Middle,	•						(First, Middle		n Sumam	ю)		
중	ould 1 Mer narks natic	2	Albert L. Sch			105 Maille				antner			04-4- 70-	0.4.1	
Z	d 2 st th and 7 is r traur		19a. Informant's Name/Relations Ellen Scheune		۵۱		ng Address (Street a Palace A							(Code)	
	1 an Heali tem 2		20a. Method of Disposition	man (NICC	20b. Pla	ce of Dispo	sition (Name of			• Paul ate	~			own, State	
ΘĽ	ages ant of it: If ii		XX Burial 2 Cremation 4 Donation 5 Other (S		State	-	natory`or other plac n Nat. Ce		1/26	/2004	Ar1	ingt	on,	VA.	
Baltimore,	permit Pages 1 Department of H Importent: If ite any injury or ot		21. Signature of Euneral Service		+		. Name and Addres Hardesty	ss of Facility Fune	ra1	Home,	P.A.				
			23a, Part1, Enter the disease, or	complications that	aused the death.	Do not ent	12 Ridge					.s, M	D 21	Approximat	te
	Pnysician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on a	dach line.									Interval Bet Onset and	
	/Medical Examiner		rosulting in doubly	Due to	or as a conseque	ence of):	ommuni	hin	1011	ived			10	DONAL	
		ē	Sequentially list conditions if any, leading to immediate	b. Due to	(or as a conseque	ence of):	CHAMMI	19 00	100	1,00			-	13	
1	uted d ansit	C .	cause. Enter Underlying Cause (Disease or injury that initiated events	S .											
30,2	cate be executed physician and the burial-transit	i Exami	resulting in death) Last	Due to	(or as a conseque	ence of):				•					
8760,	icate b physic the b	dicai		d											
.O. Box 6	The law requires that the death certific ate has been signed by the attending proage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 ☐ Live t	tcome of pregnan birth 2 ☐ Fetal on nant at time of dea own	death 3	Ectopic pregnancy Other (specify)					23d. Date Mor	e of delive	•	Year
٥.	res that the de igned by the a be detached t		Part II. Other significant condition	ons contributing to d	eath but not result	ting in the u	nderlying cause give	en in Part I.		23e. Did	tobacco	use contr	ibute to th	ne cause of c	jeath?
ds	puires n sign ald be	d by	congestive n	east pas	lue,	15che	mic Do	wel		1 🗆	Yes 2	□ No	3 ☐ Prob	ably 4 🗹	Unknown
of Vital Records,	e law requir has been si je 2 should	Completed		<i>V</i>						24a. Was		P	rior to cor	psy findings npletion of c	available ause of
E		S								1 ☐ Yes			leath?	2□ No	
Vit.	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medica examiner?	Hamitali	/		Othe	ar		(Check only					
ot		J.	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date	Inpatient 2□E	R/Outpatier 28b. Time o	IL 3 LI DOA	4 LI Nui		ne 5 🗌 Res				v)	
on	ding Phi th. : After thi tuneral	tion	1 Natural 5 ☐ Pendir 2 ☐ Accident investi	ig (Mon	th, Day Year)	Injury		k? Yes 2 □ N							
Division	f or Attending after death. Director: After in by the fune	Certification:	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place	of Injury - At honing, etc. (Specify)	ne, farm, str	eet, factory, office		2	8f. Location City or To			er or Rura	I Route Num	ber,
_	Hospite 4 hours Funerei	edical C	29a. Certifier 1 Certifyir (Check only one)	ng Physician: To the Examiner: On the b	e best of my know easis of examinationer stated.	rledge, death on and/or in	n occurred at the time vestigation, in my of	ne, date and pinion, deat	d place, a	ind due to the	cause(s , date an) and mai d place, a	nner as st	ated. the cause(s	;)
	To the within 2 To the complet	Mec	29b. Signature and title of certifie	— <i> </i>	1.00		29c. License	e number			29d. Da	ite signed	(Mgnth,	Day, Year)	
	C > F O		> Garguella	100 M		- 6-		0570	78		0	1/10	0/20	04	
	Oi		30. Nam /ard ad yess of person Jacqueline	(/				A	no1-	o MD	21/0	1			
	Sta	ete.	31. Date filed (Month, Day, Year)		2001 Me Registrar's Signatu		Parkway,	Allila	μυττ	s, MD	<u> </u>	1			
	Registi		JAN 1 4 201	P.	es M	Const									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Honth 9:20 A.M **Physician** gnier 2004 12 pT /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Glen Burnie If Under 1 Year If Under 24 Hrs. 4vundel S 8. Date of Birth (Month, Day, JULY 27, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 M 2 ☐ F **Funeral** Days Hours Min. Months 216-36-7041 94 Yrs. MARYLAND Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County or 28a-f show item 27 is marked other than "netural", or items 23a or 28a-1 show other traumatic event, it a Madical Examinar must be notified at 1 ☐ Yes Ž ☐ No Completed by Funeral Director ANNE ARUNDEL MARYLAND 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 8085 NEW CUT ROAD 21144 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed with nent of Health and Mental Hygiene. ant: If item 27 Is marked other than FARMER AGRICULTURE 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be IDA WATTS EDWARD UPTON ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2761 BAYSIDE BEACH ROAD PASADENA, MARYLAND 21122 ALLEN UPTON - SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition JANUARY 16 Department of H Important: If ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State
4 Donalin 5 Other (Specify) 2004 FRIENDSHIP CEMETERY HANOVER, MARYLAND 21. Signature o Kuneral Service Licensee k??krtev Arumifaw Funeral Home P.A. 21061 421 CRAIN HIGHWAY S.E. GLEN BURNIE, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to or a consequence of): /Medical **Examiner** Sequentially list conditions, if any, leading to infine-diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical use as I attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ď 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 No 2 🗆 No 1 🗌 Yes el or Attending Physicien: 3 s after death. si Director: After this certifica ed in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. D te of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred Certification; Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospitel or within 24 hours aft To the Funerel Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MA 0, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301

DHMH 17 Rev 1/2001

State

Registrar

31. Dale filed (Month, Day, Year)

JAN 1 4 2004

32. Registrar's Signature

			For State Registrer	State of Marylan		artment of H			jiene eg. No. 20 (14 00684
	Physicia	an	Decedent's Name (First, Middle, Lass	" Elyse	Vic	ze,	_	2. Date of Dea Month Januar	th Day Ye	
5 ~ .	/Medio Examin		4a. Fecility Name (If not institution, give		V 10		Location of Deat		4c. County of D	- 1 0000
	CXAIIIII	CI	Anne Arundel Medic			Annapo:	lis		Anne .	Arundel
	Funeral Director		14/11	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min. 1 9	8. Date of Birth (Month, Day Jan, 12		Birthplece (State or Foreign Country) Maryland
	and		Usuel Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ecation				10d. Inside City Limits
	f sho	ō	Maryland Anne	Arundel	Glar	Burnie				1 ☐ Yes 2 🙀 No
	the 128a-	Directo	10e. Street and Number	Haraci	0101	10f. Zip Code			log. Citizen of What	t Country?
	h with		12 Oak Lane SW			210	61		United	States
	eme	Funerai	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of H	ispanic Origin? (S an, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14. Race - A Black, V	American Indian, Vhite, etc.
36	within 72 hours after death with the Maryland ene. than "natural", or lleme 23a or 28a-f show the Medical Evaninar maal be notified at	by Fu	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1		1□Yes 2█ No			Specify:	White
5-0036	2 hou atura	ted	15. Decedent's Ed		16a. Dece	dent's Usual Occup	ation	-tring	16b. Kind of Busine	ess/Industry
215	thin 7	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done of DO NOT use retired	during most of wor d)	King		
2121	filed wi Hygien Sther th	Co	0		inf	ant	40.14.1.1.1.1	(F) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	infant	
Maryland	e d fa	To Be	17. Father's Name (First, Middle, Last) Michael Vice					ne (First, Middle, ice Quair		
ary	2 should and Men Is marke aumatic		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailin	ng Address (Street	and Number or Ru	ıral Route Numbe	r, City or Town, Stat	te, Zip Code)
	and 2 ealth m 27		Susan Quaintance ·				ne Pasad		yland 21.	
ore	Pages 1 nent of H ant: If ites ary or oth		20a. Method of Disposition 1 Surial 2 Cremation 3	Removal from State	cemetery, crei	sition (Name of matory or other place		Date	20c. Location - City	
altimore,	t. Partmen ntent:		`4 □ Donation 5 □ Other (Specify			lge Mem. 1		14/04	Elkridge	, Maryland
Ba	permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.		21. Signature of Funeral Service Licens Description: 23a. Pert1. Enter the disease, or comp		Ga 72	2. Name and Addres 1ry L. Kau 250 Washir	ufman Fur	neral Hon vd. Elkr	ne At MMP. Cidge, Man	., Inc. ryland 21075
8760,	death certificate be executed e attending physician and ior use as the burial-transit	Ical Examiner	shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of the consequence) Due to (or as a consequence) Due to (or as a consequence)	juence of): uence of): juence of):	de	lever	<u></u>		Interval Between Onset and Death
.O. Box 6	death certific e attending p d for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of d 9 ☐ Unknown	death 3	Ectopic pregnancy	1		23d. Date of Month	delivery Day Year
۵.	es tha	þ	Part II. Other significant conditions co	ontributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	N 2	e to the cause of death?
0.00	w requir been si should	etec						-1		
Il Records,	Physician: The law this certificate has I al director, page 2 s	Completed						24a. Was a autop: perfor 1 Yes	sy prior	
Vital	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		ot 3 DOA Oth	00	ath (Check only or		
o		on: To	1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending	1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. Injur Wor	y at k?		ence 6 Other (5 ow injury occurred	Specify)
Division	l or Attending after dealn. Director After In by the fune	ficati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	ome, farm, sti		Yes 2 □ No			r Rural Route Number,
Ω	i Cir	Certification:	4 nomiciae	building, etc. (Specil	(y) 	•		City or Tow		
	To the Hospital or within 24 hours after To the Funerel Dir completely filled in	Medical	29a. Certifier 1 Certifying Phyone (Check only one) 2 Medical Example (Check only one)	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurred at the tir vestigation, in my o	ne, date and place pinion, death occu	a, and due to the curred at the time, of	ause(s) and manne late and place, and	r as stated. due to the cause(s)
	To the within To the comp	Σ	29b Signature and title of certifier	00 01 01) /.	29c. Licens			9d. Date signed (M	
1			James Drag	lley Kalk	od 1	Da Di	4393		Januar	4 12,2004
	4		30. Name and address of person who		n 23a) (Type,	Print)	izeU 1	11/1 0010	mak	y 12,2004 21401
	Sta	to.	JAMES B. HADDO 31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	DICKE I K	-1 AM	NAMUS	, IIVI O	21401
	Regist			104	A B	and				

				e of Maryland / Department G827 1/14/04 GB	artment of Heal	Ith and Mer	ntal Hygie		00685
	J. 76		Decedent's Name (First, Middle, Last)			۷.	Date of Death Month	Day Year	3. Time of Death
3	Physici	1.0	ROOSEVELT	WASHINGTON		1		0 2004	17:32 M
Euroja Euroja	/Medic Examin	- 6	4a. Facility Name (If not institution, give street a	nd number)	4b. City, Town, or Loca	ation of Death		4c. County of Death	
	*	•	SINAI HOSPITAL ER-BA	LTIMORE	BALTIMORE			N/A	
	Funeral Director		5. Social Security Number 6. Sex 12 M 20	7. Age (In yrs. last birthday) F 63 Yrs.		ours Min.	Date of Birth (Month, Day, Y AN 9 19	(ear) Coui	place (State or Foreign ntry) H CAROLINA
264	D		Usual Residence of Decedent	Land Ch. T					10d. Inside City Limits
	how	_	10a. State 10b. County	10c. City, Town or Lo					1 K Yes 2 □ No
	Be-f.a	cto	MARYLAND N/A		BALTIMORE		100	2. Citizen of What Cou	
	or 2	Director	10e. Street and Number		10f. Zip Code		100	U.S.A.	iiu y r
	s 23s	ral	3402 COPLEY ROAD	Decedent Ever in U.S. 13.	21215	nic Origin? (Specify	Yes or No-	14. Race - Ameri	can Indian.
	ltem Dier	Funeral	Am Am	ed Forces? Yes 2 XNo	Was Decedent of Hispan If Yes, specify Cuban, Me	exican, Puerto Rica	an, etc.)	Black, White,	
36	l', or		If Y	es, Give ir or Dates:	1 ☐ Yes 2 🖾 No Sp	oecify:		Specify: BLA	CK
21215-0036	72 hours after death with the Maryland natural', or tems 23a or 28e-f ahow deat Exandrer must be notified at	Completed by	15. Decedent's Education		dent's Usual Occupation	a most of warking	16	Sb. Kind of Business/In	dustry
215	within 72 iene. than "n	ple	(Specify only highest grade comp Elementary/Secondary (0-12) Col	ege (1-4or 5+)	kind of work done during DO NOT use retired)	g most or working			
21	giene.	TO.			O MECHANIC			TONY DRILL	ING SUPPLY
2	be filed stal Hygi d other avant, I	Be (17. Father's Name (First, Middle, Last)			Mother's Name (Fi		aiden Sumame)	
/lai	should be not Mental marked o	10	CLEVELAND WASHINGTO			ROSALIE I			
Maryland	sho and and is m	6	19a. Informant's Name/Relationship (Type, Prid	•	ing Address (Street and N				
	of Health item 27		Iris Queen/Sister	20b, Place of Disp	3 Cedardale	Rd., Bal		, Maryland Oc. Location - City or T	
ore			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remova	from State cemetery, cre	matory or other place)				
Ë	Peg ment tant: lury o		* 4 □Donation 5 □ Other (Specify)	WOODLAWN	CEMETERY	01-15-	-04 W	OODLAWN, M	ARYLAND
Baltimore,	permit. Pege Department of Important: If any injury or 2052.		21. Signature of Funeral Service Licensee	8 411	2. Name and Address of WILLIAM C BI 1206 W NORT	ROWN COMM	UNITY	FUNERAL HO	ME P.A.
			23a Part1. Enter the disease, or complications shock, or heart failure. List only one caus	that caused the death. Do not en	nter the mode of dying, su	uch as cardiac or re	spiratory arres	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Δ -	ner				Onset and Death
	/Medical		a	ue to (or as a consequence of):					
н	Examiner		Conventional list conditions	metastati.	c Bran	dizens	ع		1-2 Yv
_4	D =	ner	Sequential / list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ue to (or as a consequence of).					
	nd rans	Examiner	that initiated events						
760,	e be executed /sicien and e burial-transit		resulting in deathy cast	ue to (or as a consequence of):					
876	ate b hysic the b	lcal	d						
89 x	leath certificate be execut attending physicien and I for use as the burial-trar	Physiclan/Medl	IF FEMALE: 230 Hz	es, outcome of pregnancy				23d. Date of deliv	100/
Box	ath c attend for us	lan	23b. Was decedent pregnant	Live birth 2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			Month	Day Year
0	0 0 0	ysic		Unknown					
a	that the de red by the detached	P.	Part II. Other significant conditions contribution	ng to death but not resulting in the	underlying cause given in	Part I.	23e. Did toba	acco use contribute to	the cause of death?
of Vital Records,	w recuires that s been signed b should be deta	d by					1 ☐ Yes	2 □ No 3 □ Pro	bably 4 @Unknown
5	law recuires as been sign 2 sho ild be	Completed					24a. Was an	24b. Were aut	opsy findings available
Re	e la hae	d L					autopsy	ed? death?	ompletion of cause of
a	icina: Th certificate rector, pag		25. Was case referred to medical		26	. Place of Death (C	1 Yes 2		21,440
5		o Be	examiner?	l: 1 ☐ Inpatient 2 ☑ER/Outpatie	Othor			rce 6 □Other (Speci	ifv)
of	Phys er this eral di	⊢	27. Manner of Death 28a	Date of Injury 28b. Time	of 28c. Injury at			v injury occurred	
lon	ath. r: After he funer	텵	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury		2 No			
Division	spitel or Attendi ours after death. neral Director: A filled in by the ft	Certification:		Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f	Location (Stre	et and Number or Rui State)	al Route Number,
Ö	el or s afte	Cert	1 Torricos	building, oto. (opoony)			,		
L	Fug P b	Medical ((Check only 2 Medical Examiner: O	To the best of my knowledge, dean the basis of examination and/or and manner stated.	ath occurred at the time, d investigation, in my opinio	date and place, and on, death occurred	due to the car at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within 2 To the comple	₩	29b. Signature and title of certifier		29c. License nui			d. Date signed (Month	, Day, Year)
	PSPO		mian-0 Ki	surp I mas	0310	565		1/13/0	4
	3		30. Name and address of person who complet	ed cause of death (Item 23a) (Type					-
	_		Rm 206 82		street	Baetin	re!	md 21	20/
	S: Regis	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	•				
	ricgis	فلتعد	JAN 1 4 2004 A	Marine 18 Dage	608				

State of Maryland / Department of Health and Mental Hygiene 🤈 🖺 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 4:12 PM **Physician** 2004 January RODNEY LEE WILSON SR. /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltonere City Baltamore Sinai Hospital 04 N/A 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Min XXM 2□F Yrs. AUG 29 1956 VIRGINIA Director 220-64-7783 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State item 27 is marked other than "naturel", or items 23e or 28e-f shov other traumatic event, it a Medical Exactinar must be molified at 1 ∑Yes 2 ☐ No Director BALTIMORE MARYLAND N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A.

14. Race - American Indian, 21215 3900 BAREVA RD Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes 2 No Specify: ۵ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 2121 College (1-4or 5+) Elementary/Secondary (0-12) GENERAL MOTORS MILL RIGHT MACHINEST 12th grade 1 yr 18. Mother's Name (First, Middle, Maiden Sumame) land 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If tiem 27 Is marked any injury or other traumatic average. BERTINA TAYLOR WILSON ဂ RAY LEE WILSON Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, Maryland 21215 Deborah A Wilson/Wife 3900 Bareva Rd., Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donetion 5 ☐ Other (Specify) SHILOH BAPT CHURCH 01-17-04 REEDVILLE, VIRGINIA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. harles Jource 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1206 W NORTH AVENUE Approximate Interval Between Onset and Death Immediete Cause (Final Sepsis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Tubular Acidosis Renal Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and Due to (or as a consequence of): Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ 9 ☐ Unknown 2 🗆 No detached o 9 Unknown δ of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. sign be 3 Probably 4 Unknown Failure 2 No Reinal hepatic energhalopathy 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 s autopsy performed?

1 Yes 2 No funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ▼Inpatient 2 □ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3□ DOA Certification; To this 28c. Injury at Work? 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred Injury or Attending 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funerel Director: A 2 Accident the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide filled in by 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the Fun completely (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier RES -000 Jahuary 7, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospital , Baltimore, Maryland 21215 Kweku Hayford, MD., 2. Registrar's Signature 31. Date filed (Month, Day, Year) State free! JAN 1 4 2004 Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Wilson

odnoy

92

as

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

 $W_{i}M_{i}$ M M M M M M M Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	1	- State Amend Item 27,28a-Registrar	-fper ME.,G	1791and / 1 327,01/27	Jepai /egh	ficate of D	eaith and r Death	vieritai myt	Reg. No.	200	4 00685
		Decedent's Name (First, Middle, Last)			-			2. Date of Dea	th Day		3. Time of Death
Physician /Medical		Mike Willia	ns					JANUAR		3 20	04110; 10 A M
Examiner Funeral	1	4a. Facility Name (If not institution, give: On I V CRS IT C 5. Social Security Number 6. Sex	pecialel	Vin yrs. last Bi	- 1	4b. City, Town, or I Bo C If Under 1 Year Months Days	Location of Death MORC If Under 24 Hrs. Hours Min.	8. Date of Birtl	h /, Year)	9. Bi	rthplace (State or Foreign
Director		220-84-7558 Usual Residence of Decedent	JW 201	75	Yrs.			Nov. 29	, 19	28 Kc	rea
show		10a. State 10b. County	a	10c. City, Tow							10d. Inside City Limits 1 ☐ Yes 2√2 No
vith the Mai	ŀ	Maryland Howard	a	EIII	COLL	City 10f. Zip Code			10g. Citize	en of What C	Country?
3a or		9067 Northfield R	oad			21042	2		Uni	ted St	ates
ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "naturel", or items 23a or 28e-f show or other treumatic svent, the Medical Examinational be notified at To Ba Completed by Filneral Director	5	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Tyes 2 Tyes If Yes, Give Year or Dates:		1	/as Decedent of His Yes, specify Cubar ☐ Yes		pecify Yes or No- o Rican, etc.)		4. Race - Am Black, Wh Specify:	erican Indian, ite, etc. Asian
72 ho		15. Decedent's Edu (Specify only highest grad		16a	. Decede (Give k	ent's Usual Occupa aind of work done di ONOT use retired)	tion ur <i>ing m</i> ost of wor	rking	16b. Kind	d of Busines	s/Industry
ed within 72 houygiene.		Elementary/Secondary (0-12)	College (1-4or 5	,		ess Owner	r .			li Gro	cery
2 should be filed within and Mental Hygiene. Is marked other than eumatic svent, the March and To Re Comp.	3	17. Father's Name (First, Middle, Last)	unk.				18. Mother's Nan	ne (First, Middle,	Maiden S	iumame)	unk.
shou and M s mar		19a. Informant's Name/Relationship (T)				g Address (Street a					
and 2 eaith m 27 I	1	Sheena Kwon - Dau	ghter			Northfie		Ellicot			ryland 21042 r Town, State
permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tre- QDC9.		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)				ition (Name of latory or other place Ige Mem. I	I				Maryland
permit. Departn Imports any Inju		21. Signature of Funeral Service Licens	99		Ga 72	Name and Address ry L. Kau 50 Washir	s of Facility ufman Fu ngton Bl	neral Ho vd. Elk	me A	t MMP. e, Mar	Inc. vland 21075
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused ne cause on each li	the death. Do	not ente	er the mode of dying	, such as cardia	c or respiratory ar	rest,		Approximate Interval Between Onset and Death
Physician	1	Immediate Cause (Final disease or condition	a. Con	icle	3/	ine 1	minsy				2/2 42
/Medical Examiner	1	resulting in death)	m	a consequence	1 0		,				2.1/2 400
	<u>.</u>	Sequentially list conditions, if any, leading to immediate	b	a consequence	of):	fre					0/2/
uted d ansit	0	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Dra	betes	m	elli Ins		11			Sect.
executed an and rial-transit	בא בא	resulting in death) Last	Due to (or as	a consequence	of):		Λ	11/1/			
ficate be executed physician and is the burial-transit	Calcal		d			-	-NA	EXAMINER .			
n certifica anding pl use as t		IF FEMALE:	23c. If yes, outcome	of pregnancy		-	ODROVED BY	I Car	2.	3d. Date of d	elivery
The law requires that the death certificate be tale has been signed by the attending physicic page 2 should be detached for use as the but	ysician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal deat	th 3 🗆 5 🗆	Ectopic president)			Month	Day Year
w requires that been signed by should be deta	a by Pr	Part II. Other significent conditions of	entributing to death b	ut not resulting	in the un	nderlying cause give	en in Part I.	1			to the cause of death? Probably 4 🎵 Únknown
The law requate has been page 2 shoul	Completed								rmed2	prior to death?	autopsy findings available o completion of cause of
		25. Was case referred to medical					26. Place of De	ath (Check only o	2ØNo ne)	1 □ Ye	35 2 NO
Physician: this certifical	o pe	avaminar?	Hospital: 12 Inpati	ent 2 ER/C	Outpatient	t 3 DOA Othe	er: 4 🗌 Nursing I	Home 5 ☐ Resid	dence 6	□Other (Sp	necify)
Attending Physician: or death. ector: After this certific by the funeral director,		27. Manner of Death 1. ☑Natural 5 ☐ Pending 2X Accident investigation	28a. Date of Inju (Month, Da October 1	y Year)	Time of Injury 3:p	Work	rat ⟨? Yes 2. XX.No	28d. Describe I	_	occurred	
or Atter after dea Director in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In	ury - At home,	farm, street	eet, factory, office		28f. Location (3 4013 High	Street and yn, State) Land A	Number or a	Rural Route Number, alto.,MD21225
	Medical C	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best liner: On the basis of and manner st	if examination a	ge, death and/or inv	n occurred at the time restigation, in my op	ne, date and place pinion, death occ	e, and due to the urred at the time,	cause(s) a	and manner place, and d	as stated. ue to the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier				29c. License	number 4974				nth, Day, Year)
5		30. Name and address of person who of the Ru MEHTA,		South	(Type,				re, r	4021	230
Stat Registra		31. Date filed (Month, Day, Year)	32 Regist	rar's Signature							
riegistic		JAN 1 4 (UU	4 Dage	I K	400						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	1 - For Stete Registrar	State o	f Marylan		artmen rtificat			ind M		giene Reg. No.	200) L ₃	00690)
	5 1		1. Decedent's Name (First, Middle,	Last)							2. Date of Dea	ath Day)	/ear	3. Time of Death	
	Physicia /Medic		Esther	I			Viel	bb			Januar			204	9:00a M	1
	Examin		4a. Facility Name (If not institution,	give street and nu	mber)		4b. City,	Town, or	Location of	f Death		4c.	County of	Death		
			William Hill	Manor					ston				Τε	albo	t	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under Months	1 Year Days	If Under:	24 Hrs. Min.	8. Date of Birt (Month, Da	v. Year)	1	Coun		n
	Director		218-09-5053	1□M 2∏F	82	Yrs.					Jan. 23	, 19	21	Ma	ryland	
	2		Usual Residence of Decedent 10a. State 10b. County		10c Cit	ty, Town or Lo	cation							10	Od. Inside City Limits	
	shor	۱ ا			100.01	ty, rount of Lo	041011								1 ☐ Yes 2X No	
	8a-f	ect		bot				ston	1.			10- Citi-	zen of Wh			_
	Te or	ä	10e. Street and Number				10f. Zip					rog. Citiz			,	
	8 236	Funeral Director	28082 Oakland Ci		- d1	10 10	W - D		601	-:-0 (0-			U . 14. Race -	S. A		
	iten	Ľ,	11. Marital Status	Armed Fo		.5.	f Yes, spec	cify Cuba	n, Mexican	, Puerto	ecify Yes or No- Rican, etc.)	' '		White,		
9	rs an	by F	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	ld 1 □ Yes If Yes, Gir Year or D	AB Z TXI MO		1 ☐ Yes	2 X No	Specify:				Specify:	τ.π	nite	
3.	non true	ba l	15. Decedent's		atos.	16a. Dece	dent's Usua	al Occupa	ation			16b Kir	nd of Busi			
2	27 ui	Completed	(Specify only highest	grade completed)		(Give	kind of wo	rk done o se retired	furing most	of worki	ng				ırity	
4	ther ther	Ē	Elementary/Secondary (0-12) Unknown	College (1-4or 5+)		C1er								ration	
3	Hyg Hyg Sther ent,		17. Father's Name (First, Middle, L	ast)					18. Mothe	r's Name	(First, Middle,				<u>cacion</u>	
5	ental ental ked (To Be	Walter Sauner H	Jangon						Mai	y Cook					
	Should Marian	-	19a. Informant's Name/Relationshi			19b. Mailir	ng Address	(Street a	and Numbe		l Route Numbe	er, City or	Town, St	ate, Zip	Code)	
2	ith al 27 is r treu		Mrs. Lynn Johnso	on (Niece)	28082	0ak1	and	Circl	e, I	Easton,	Mary	yland	1 21	601	
ָט ע	Hea Hea tem othe		20a. Method of Disposition		20b. F	Place of Dispo cometery, crei	sition (Nar	ne of	0)		ate	20c. Loc	cation - Ci	ity or To	wn, State	
2	y or		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (Sp.		State	ayview			· 1	/10/	2004	Balt	imor	e. M	aryland	
	permit. Pages 1 and 2 should be lited within 72 hours after death with free maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Begins of Health and Mental Hygiene. By njury or other treumatic event, if a Marical Examinar must be notified at an one.		21. Signature of Funeral Service L			-					imunek					-
	Department of the sample of th		1/1/1/18	1 :	1						altimo:					
	3	32	23a. Hart1. Enter the disease, or shock, or heart failure. Lin o	omplications that of	aused the deat								142) 3		Approximate	
	security and		shock, or heart failure. Lim of Immediate Cause (Final	nly one cause on							,	,			Interval Between Onset and Death	
ď	hysician /Medical		disease or condition resulting in death)	_ a	leumen										WRIKS	
	Examiner			Due to	or as a conseq	rence of):	1/2	Tuno	,						nears	
		-6	Sequentially list conditions,	b. Due to	(or as a conseq	uence of):	jani	wo							1	
	nsit	Ë	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Un	ordens	Hon									years	
•	eath certificate be executed attending physician and for use as the burial-transit	Examiner	that initiated events resulting in death) Last	cDue	(or as a conseq	mence of).		- 1						-		
3.	siciar buri			ASTI	resosale	200513, 1	gene	ralize	ed					ì	years	
	phy:	Physician/Medical		- d		1	'					-				
<	certi nding se a	Ž	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna							2	3d. Date of	of delive	v	
ว์ วั	atter	ciar	in the past 12 months?		ointh 2 ☐ Fete nant at time of d]Ectopic pr] Other <i>(sp</i>						Month		Day Year	
j į	y the	ysi	1 ☐ Yes 2 No 9 ☐ Unknown	9□Unkn	own											
	w requires that the death cer been signed by the attendin should be detached for use		Part II. Other significant condition	s contributing to d	eath but not res	sulting in the u	nderlying c	ause give	en in Part I.		23e. Did to	bacco us	se contrib	ute to the	e cause of death?	
2	ures r sigr	d by	Deep Vein	- 1 Work	50514						1 🗆 Y	es 2]No 3	Proba	ibly 4 DUnknown	n
5	A req	jete	Colly litis &	1 lower	extre	nities					24a. Was	an	24h We	re autor	sy findings available	A
ַ עַ	has be 2	Completed	Committee	, , , , , , , ,	7-1-9041	74/-		· · · · · · · · · · · · · · · · · · ·			autop		pric	or to com ath?	pletion of cause of	
ָ ק	icate		05.04									2 2 40	1 🗆	Yes	2 No	
= :	certii recto	o Be	25. Was case referred to medical examiner?	Hospital:		155/0		Othe	The Late of the La		(Check only o			10		
5 ;	nding Physicien: The law th. :: After this certificate has b • funeral director, page 2 st	-	1 ☐ Yes ②K☐ No 27. Manner of Death	28a. Date		ER/Outpatier 28b. Time o	_	8c. Injury Work	4 34 VU		me 5 🗆 Resid)	_
5 :	After fune	tion	Natural 5 ☐ Pending	(Mon	th, Day Year)	Injury	М		(?¨ Yes 2.⊟1			, ,				
2	deat deat ctor: y the	fica	3 ☐ Suicide 6 ☐ Could no	ot be	of Injury - At he	ome, farm, str	eet, factory	, office			28f. Location (S	Street and	l Number	or Rural	Route Number,	-
2	after Dire	ertification;	4 Homicide determin	build	ing, etc. (Specif	fy)	,,	,			City or Tow	m, State)				
-	o the Hospital or Attending Priystoen: The law requires that the death certificate be executed within a starter death. Attending physician and the Funerel Director: After this certificate has been signed by the attending physician and commetely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	O	29a. Certifier Certifying	Physician: To the	e best of my kno	owledge, deat	n occurred	at the tim	e, date an	d place.	and due to the d	cause(s)	and mann	er as sta	ited.	-
:	e Fur e Fur etely	edical	(Check only 2 Medical E	xaminer: On the b	asis of examina ner stated.	ation and/or in	vestigation	, in my op	oinion, deat	h occurr	ed at the time,	date and	place, and	d due to	the cause(s)	
	To Thin	Me	29b. Signature and title of certifier	May V	101		290	. License	number	2000		29d. Date	signed (i	Month, E	Day, Year)	
1	1		\	1899 DU	en/ we	>		1	ワで	15	,		1.9.	04		
1	7		30. Name and address of person w	no completed cau	of death (Item	m 23a) (Tyne	Print)							,		
1	り	\vee	Michael Crowl	4	/			ine.	East	on. N	Marvlan	d 216	501			
Ľ	Sta	ite	31. Date filed (Month, Day, Year)	32. F	Registrar	ature	الد الد	,		, .	J					
	Registr		JAN	1 4 2004)	A Carlos	as It.		will								

			For State	State of Maryland	Department of Health a		2006 00601
			Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of Death	Reg. No	3. Time of Death
П	Physici	an	M () i () i ()	1	1):00:05	Month Da	
	/Medic		4a. Facility Name (If not institution, give st	reet and number)	4b. City, Town, or Location of		: County of Death
	Examin	er	8203 Mitni	ck Rd	ΨΟΘ. 11:00	ore	Paltimore
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last			9. Birthplace (State or Foreign Country)
	Director		213-40-0103	M 200 F 63	Yrs.	12-7-4	O MARYLAND
	and and	}	Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Location	**	10d. Inside City Limits
	Many -1 sh	ţ	MA PAIT	MORE P	SALTIMORE		1 Tyes 2 No
	r 28a	lrec	10e. Street and Number	0 1	10f. Zip Code	10g. Ci	itizen of What Country?
	23a c	Funeral Director	8203 Mitnic	k. Koad	2123	le.	USA
	tams	nue	1.	2. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Oric If Yes, specify Cuban, Mexican	nin? (Specify Yes or No- , Puerto Rican, etc.)	 Race - American Indian, Black, White, etc.
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married ☐ 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2/12 No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: // hite
ğ	2 hou		15. Decedent's Educ	ation 1	6a. Decedent's Usual Occupation (Give kind of work done during most	16b. H	Kind of Business/Industry
215	ithin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)	or working	/
7	led w lygier her th		17 Februario Nierro (Firms Middle (1998)	2	WRGICOU TIURS	e, H	ospital.
and	ntal Hed ot	Be	17. Father's Name (First, Middle, Last)	and Bakar	18. Mothe	rs Name (First, Middle, Maider	OD in a Coall
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Menial Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Madical Examinat must be notified at	은	19a. Informant's Name/Relationship (Typ	e, Print)	9b. Mailing Address (Street and Numbe	r or/Aural Route Number, City	or Town, State, Zip Code)
	and 2 ealth a n 27 is		Kermit Wiga	ios SR	t203 Mitnick	Koad Bult	imore MD
Ze,	es 1 a of Hei litem		20a. Method of Disposition 1 Ø Burial 2 □ Cremation 3 □ Re	com/	of Disposition (Name of stery, crematory or other place)	Date 20c. L	ocation - City or Town, State
altimore,	Pages ment of lant: If it		*4 □Donation 5 □Other (Specify)	Holy	RodoemerConutry	1-15-04 Pa	Chimore, MD
Ball	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trae		21. Signature of Funeral Service License	1. 1	22. Name and Address of Facility		ND 21234.
	40369		23a. Part1. Enter the disease, or complic	ations that caused the death.	O not enter the mode of dying, such as		HARFORD RD Approximate
	進		shock, or heart failure. List only one	cause on each line.	/ -	saldiac of respiratory affect,	Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	Due to (or as a consequent		A melo	N/ 11:EAS
	Examiner		Sequentially list conditions b.				
	D #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	Due to (or as a consequent	ce of):		
	and trans	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequent	ca of):		
8760,	cate be executed physician and the burial-transit	aiE		200 (0) 03 0 00113040311	oo or).		
687	ificate g phys as the	edlcai	0.				
Box	eath certific attending p	Z/M	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregnancy			23d. Date of delivery
O. B	e death	Physiclan/Me	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time of death			Month Day Year
٦. O	that the de led by the a detached i	Phy	9 Unknown		a in the made him and a sum in Boat I	22a Did tahana	una anatributa ta tha anuna af danth?
ds,	Se Po	b	Part II. Other significant conditions conf	mbuting to death but not resulting	g in the uncertying cause given in Part I.	1 ☐ Yes 2	use contribute to the cause of death?
Records,	w require been si should t	etec				-	
Rec	The lav	Completed				24a. Was an autopsy performed? 1 ☐ Yes 2 € No.	24b. Were autopsy findings available prior to completion of cause of death?
Vital			25. Was case referred to medical		26 Place	1 ☐ Yes 2 🕰 No of Death (Check only one)	1 ☐ Yes 2 ☐ No
	Physiclen: r this certific ral director,	To Be	examiner?	ospital: 1 Inpatient 2 ER/	Othor	rsing Home 5 X Residence	6 □Other (Specify)
0	ng Phys ter this neral di		27. Manner of Death	28a. Date of Injury (Month, Day Year) 28	b. Time of 28c. Injury at Injury Work?	28d. Describe how inju	
Division of	Attending or death. ector: After by the fune	catle	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 N	No	
Ž	al or Attending Patter death. Director: After to in by the funera	Certification:	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, street, factory, office	28f. Location (Street ar City or Town, State	nd Number or Rural Route Number, e)
	spital ours a neret l		29a. Certifier 1 Certifying Phys	cian: To the best of my knowled	dge, death occurred at the time, date and	t place, and due to the cause(s	and manner as stated
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical	(Check only 2 Medicel Exemin	er: On the basis of examination and manner stated.	and/or investigation, in my opinion, deat	h occurred at the time, date and	d place, and due to the cause(s)
	To the To the Comp	Ň	29b. Signature and title of certifier		29c. License number	29d. Da	ite signed (Month, Day, Year)
)	^		Vaul Clan	\$, mo	D1658	+ '/	12/04
	10		30. Name and address of person who cor	/		1.12 12.11	
	Sta	te	31. Date filed (Month, Day, Year)	32. Register's Signature		16107, Balts, 1	40 d. ld 37
	Registr		JAN 1 4	2004 \ 1800000) 18 Locales		

			For State Ragistrar	State of	Marylar			nt of He te of D		Mental Hy	ygiene Reg. No	7 11111	4 00692
	Physicia /Medic		1. Decedent's Name (First, Middle, & ANNA		WEITZ	EL				Janua	eath 1ry Day	10,200	3. Time of Death 6:19 A M
	Examin Funeral	er		rial Hosp	ital	last birthday) Yrs.]	reder	ick If Under 24 Hr Hours Mir	s. 8. Date of 8	irth Day, Year)	9. Bi	erick rthplace (State or Foreign country)
	Director	J.	216-24-7865 Usual Residence of Decedent 10a. State 10b. County MD Freder	X	73	ty, Town or Lo		lerick		⊥Feb 1	, 193	BO Ma	aryland 10d. Inside City Limits 1 □ Yes 2 ☑ No
	h with the N 3a or 28a-f	al Director	10e. Street and Number 5760 Bartonsvi					Zip Code 217			-	izen of What C	
336	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f ehow aumatic event, the Madisal Examinat must be notified a	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Wivorced	12. Was Deced Armed Ford 1	es? ∰No	'	f Yes, sp	edent of His ecify Cuban 2 No	panic Origin? (, Mexican, Pue Specify:	Specify Yes or N rto Rican, etc.)	lo-	14. Raca - Am Black, Wh Specify: W	ite, etc.
21215-0036	within 72 hou ane. then "nature ne Medical E	Completed by	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)		lor 5+)	(Give	kind of N DO NOT	use retired)	ion uring most of w erator	orking		ind of Busines:	
Maryland 2	\$ 12 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	To Be Co	17. Father's Name (First, Middle, La John Bauer	st)		DWILL	.1100		18. Mother's Na	ame (First, Middl Le Calen	e, Maiden		<u> </u>
	s 1 and 2 should if Health and Mer item 27 is marke other traumatic		19a. Informant's Name/Relationship Mrs. Michele Hi 20a. Method of Disposition				Co1	lidge		Bural Route Num. Sykesvil.	le, M		4
Baltimore,	permit. Pages Department of the Important: If Ite ony injury or of		1 X Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	cify)	ate La	ake Vie	matory of W Me	em. Pa	1	.4/2004	Syke	sville	, MD
eg M	Perr Dep Perp Perp Perr		23a. Part1. Enter the disease, or co shock, or heart failure. List on	implications that cally one cause on ear	sed the dear		Syke	esvill	e, MD 2	ME & CH. 21784 (4) ac or respiratory	10)-7	PA (B) 95-140	Approximate Interval Between Onset and Death
8760,	Physician / Medical Examiner and publicities and physician and the private in the	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (o	r as a consec r as a consec r as a consec	quence of):	bnt	5-0	Cerebr	ral bir	ed.		ZIWK.
Box 6	The law requires that the death certifical title has been signed by the attending plage 2 should be detached for use as I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2 ☐ Feta ntat time of c	aldeath 3 ☐	Ectopic Other	pregnancy specify)				23d. Date of de Month	blivery Day Year
Records, P.O.	w requires that the book of the control of the cont	by	Part II. Other significant conditions	s contributing to dea	th but not res	sulting in the u	nderlying	cause give	n in Part I.		tobacco u		to the cause of death?
		Completed	25. Was case referred to medical							per 1 ☐ Yes	opsy formed? 2 X No	prior to death?	utopsy findings available completion of cause of s 2 \sum No
Division of Vital	ling Phys o. After this funeral dii	atlon: To Be	examiner? 1 Yes 2 No 27. Manper of Death 1 Death 2 Accident investigat			ER/Outpatien 28b. Time of Injury		Other 28c. Injury Work	4 ☐ Nursing	eath (Check only Home 5 Res 28d. Describe	sidence		acify)
Divis	vital or Attendi urs after death. vrel Director: A	Certification:	3 Suicide 6 Could no determina	building	j, etc. (Speci					City or To	own, State)	tural Route Number,
,	To the Hospital or Att within 24 hours after of To the Funerel Direct completely filled in by	Medical	29a. Certifier 1 Certifying 2 Medical Exone) 29b. Signature and title of certifier	Physician: To the baseminer: On the base and manner	is of examina	ation and/or in	vestigati	on, in my opi	nion, death occ	ce, and due to the curred at the time	, date and	and manner a d place, and du te signed (Mon	e to the cause(s)
)	\ <u>\</u>		30. Name and address of person wh	MD.	of death (Ite	m 23a) (Type.	Print)	000	6041	7 -	1 -	11:04	
	Sta Registr		Hemen Shah 31. Date filed (Month, Day, Year) IAN 1 4 2004	MD 6.	gistrar's Sign	Thom,	us-	Johns	sen Dr	1. Tre	dev	ick	MD-21702

		1 - For State Registrar	State of Marylan			nt of He			Reg. No	Z 1111	4 00693
Physici		Decedent's Neme (First, Middle, Las Cather	ine W. Wade					2. Date of Month Janu	Da	ž, 2004	3. Time of Death 8:10 a M
/Medic Examir		4a. Fecility Name (If not institution, give 615 Chestnut Av			4b. City.		ocation of [Death		.County of De Baltimo	
Funeral Director		5. Social Security Number 6. Se		last birthday) Yrs.	If Unde Months	n 1 Year Days	If Under 24 Hours	Hrs. 8. Date of (Month) June	, Day, Yeer,		linthplace (State or Foreign Country) lary land
yland		Usuel Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Lo	ocation						10d. Inside City Limits
the Mar 28a-fal	ector	Md. Baltimor 10e. Street and Number	e To	wson	10f. Zi	p Code			10g. Ci	tizen of What	1 ☐ Yes 2 🙀 No Country?
th with 23a or	al Dir	615 Chestnut A	ve. #1222			212			L.,	USA	
inition (e.) Mail yield a first 2000. Init. Pages 1 and 2 should be filed within 72 hours after death with the Maryland ariment of Health and Mental Hyglene. Ortant: if Item 27 is marked other than *natural*, or Items 23a or 28a-f ahow injury or other traumatic event, the Medical Examination to build a marked. B.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Dece If Yes, spe 1 \(\text{Yes} \)		panic Origin , Mexican, F Specify:	n? (Specify Yes o Puerto Rican, etc.	r No-)	14. Race - Ar Black, Wi Specify:	merican Indian, hite, etc. White
hin 72 hou.	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	16a. Dece (Give life.	kind of w	ial Occupat ork done di use retired)	tion uring most o	of working	16b. F	(ind of Busine:	
be filed with tall Hygiene dother than event, the		12 17. Father's Name (First, Middle, Last)		Homer	naker		18. Mother's	s Name (First, Mic	ddle, Maidei	Own H	lome
arytarical should be file and Mental Hy marked oth umatic even!	To Be	Wesley Warre	n			n and a second	Maz	ie Hild			
and 2 sho ealth and I n 27 is ma		19a. Informant's Name/Relationship (19mm) Mr. Harold Wade,	** *					or Rural Route No #1222 To			
of Hea		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	Place of Disposemetery, cre	matory or	other place		Date			or Town, Stete
DEMILIAGICE, permit. Pages 1 a Department of Hes important: if Item any injury or othe		* 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen	<u>Dul</u>	laney 2	2 Name a	nd Address	s of Facility	-14-04		monium, -	Md.
De any grand any or a		1 exty	5		Ruc 105	k Tow O Yor	son F k Rd.	uneral H Towson,	ome, Md.	Inc. 21204	
Physician /Medical		23a. Part 1. Enter the dise se, of com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	EAST				ardiac or respirato	ory arrest,		Approximate Interval Between Onset and Death
Examiner	Jer	Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying	b. Due to (or as a conseq	tianna of):				1 1 444 10 1			
ate be executed sysicien and he burial-transit	cal Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a conseq	uence of):							
ng phys		IF FEMALE:	d								
at the death certification by the attending phy tached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3	⊒Ectopic p ⊒ Other (s					23d. Date of o	delivery Day Year
Sy se this	by	Part II. Other significant conditions of	ontributing to death but not res	sulting in the o	underlying	cause give	n in Part I.	11000	Did tobacco 1 □ Yes 2		e to the cause of death? Probably 4 Unknown
Hec e law has t	Completed								Was an autopsy performed?	prior	
Or VICAL Physician: The This certificate ral director, page	Be	25. Was case referred to medical examiner?	Hospital:			Othe		of Death (Check of	nly one)		
Phys raldi	n: To	1 ☐ Yes 2☒ No 27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time		28c. Injury Work	4 🗆 14013	sing Home 52 28d. Desc	Residence ribe how inji		pecify)
DIVISION Of or Attending Fafter death. Director: After tin by the funer	Certification;	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	e 290 Place of laiunt - At h	Injury ome, farm, si fy)	M treet, facto	1 🗆 Y	ves 2 □ No	28f. Locati	ion (Street a r Town, Stai	nd Number or 'e)	Rural Route Number,
To the Hospital or A within 24 hours after To the Funeral Director of the Completely filled in b	edical Ce		nysician: To the best of my kno niner: On the basis of examina and manner stated.								
To the within 2 To the comple	Mec	29b. Signature and title of certifier	D c A		2	9c. License	number		29d. D	ate signed (Mo	onth, Day, Year)
6		191 Hother	y Kiley, is	n 330) (T	Deine*	1)25	205		JA	10 Ary	12,2004
9		30. Name and address of person who	Smc 6701	m 23a) (Type	(ha	les	54.	Balto	. Md	212	04
St	ate	31. Date filed (Mary), Day, 4ea 200	32. Registrar's Sigh	ature	all s						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death UUL Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Physician January 11 2004 /Medical 4b. City. Town, or Location of Death 4c. County of Death Facility Neme (If not institution, give street and number) Examiner Maris Baltimore Social Security Number If Under 24 Hrs. 7. Age (În yrs. last birthday) If Under 1 Year 6. Sex **Funeral** Months Deys Hours 1 M 2 F Yrs. - albalo Director Usuel Residence of Decedent permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a.s. any injury or other traumatic source. 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Baltimore MD NIA 1 Yes 2 □ No **Funeral Director** 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2/3 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1□Yes 2☑No Specify: Black Be Completed by Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) XYrs. 17. Fether's Name (First, Middle, Last) (First, Middle, Maiden Sumame) alte b. Mailing Address (Street 0. BOX 280 19a. Informant's Name/Flelationship (Type, Print) or Rurel Route Number, City or Town_State, Zip Code) 23/09 Matthews orother 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cregration 3 Removal from State 15 DiOther (Specify) Epitombment WindSor Park Mausoleum 4 Donation irginia 21. Signature of Funeral Service Licens 22. Name and Address of Facility or the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical 6 Examiner Due to (or as a consequence of): Completed by Physician/Medical Examiner igned by the attanding physician and be datached for usa as the bunal-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Box 68760. Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? has this certificate ZVINO 11 I Yes 1 ☐ Yes 2 ☐ No edical Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 4□ Nursing Home 5□ Residence 6 Ø Other (Specify) # OSDice eral Director: Aftar th 27. Manner of Death 28b. Time of Injury 28c. Injury et Work? 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Direct completely fillad in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es steted.
2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier (Check only one) 29b. Signature end-title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) 13/2004 40854 30. Name end eddress of person who compléted cause of death (Item 23e) (Type, Print) Baltimore Riseburg 301 32. Registrer's Signature 31. Date filed (Month, Day, Year) State JAN 1 4 2004 Registrar

			1 - State	State of Marylar	nd / Depa			ental Hygi	ene	. 00605
			1. Decedent's Name (First, Middle, Las	t)	001	inicate or	Dealit	2. Date of Death	g. No. C. U U	3. Time of Death
	Physic	an		Wade_				Month	Day Year	1 01.00
	/Medi		Geraldine			41 - 6% - T		Jan	200	7 1 1 1 1 1 1
1	Examir	ner	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	L Location of Death		4c. County of De	1.0
	· ·		5. Social Security Number 6. So	7 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	for an include of a 1	If Under 1 Year	If Under 24 Hrs.	0.0		UJA
	Funeral			7. Age (In yrs.		Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) 9. B	irthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	/ 8				July 20	10125	MD
	land ow		10a. State 10b. County	10c. Ci	ity, Town or Loc	ation	· · · · · · · · · · · · · · · · · · ·			10d. Inside City Limits
	Mary	ŏ	MD NI	4	Ban 14	inore				1 HTES 2 No
	28a-	90	10e. Street and Number	/ .		10f. Zip Code		100	g. Citizen of What 0	`austry?
	with	ă	3723 Beek	der an			215	,0,		
	is 23	Funeral Director	11. Marital Status	12. Was Decedent Ever in U	IS 12 W			oifu Voc or No-	14. Race - Arr	
	Itam Itam	5	1 Never-Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No	7.3. If	Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto F	Rican, etc.)	Black, Wh	
36	Ir, or	by F	3 ∰Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1	Yes 2 No	Specify:		Specify:	Black
21215-0036	be tiled within 72 hours atter death with the Maryland nat Hygiene. ad other than "natural", or Itams 23a or 28a-1 show event, the Medical Examinar must be rediffed at	ed	15. Decedent's Ed	ucation	16a, Decede	ent's Usual Occup	ation	16	3b. Kind of Busines	•
15	in 72	Completed	(Specify only highest gra-	de completed)	(Give k	and of work done	during most of working	ig .	55. 14110 01 5001100	a modelly
12	filed withi Hygiene. other than	E G	Elementary/Secondary (0-12)	College (1-4or 5+)		TOOK			Batto C	ity seoils
0	filed Hygir other		17. Father's Name (First, Middle, Last)	1911		•	18. Mother's Name			
an	Mental Mental arked o	To Be	George Pa	ge			Ruth	, Hai	1.1	
Maryland	s 1 and 2 should be t Health and Menta item 27 is marked other traumatic ev	F	19a. Informant's Name/Relationship (7	<u></u>	19h Mailing	Address (Street			<u> </u>	Zip Code) 21117
S	d 2 s th ar th ar trau			Wade	4410		oHsville	-		
	1 and 2 Health tem 27		20a. Method of Disposition		Place of Dispos				Oc. Location - City o	
و	0 0		1 🕒 Burial 2 🗆 Cremation 3 🗆	Removal from State	cemetery, crem	atory or other place	ca) .			
ţ	nit. Paratmeni ortant: injury		'4 □Donation 5 □Other (Specify		179	rark		8104 1	noundalls	stoun, mo
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licen	,ee /	22.	Name and Addres	ss of Facility	reend	· Funero	isex.
	00 = 00		1 Vaughi C	7 min	5	151 Bai	to. Nest'	L PIKC	Ba 14	omo 2177
			23a. Pert1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the deat ne cause on each line.	th. Do not ente	r the mode of dyin	g, such as cardiac or	respiratory arres	t,	Approximate Interval Between
188.	Physician		Immediate Cause (Final disease or condition	. A cute	M.	(-				30 wts
	/Medical		resulting in death)	Due to (or as a conseq	quence of):					00112
4	Examiner		Sequentially list conditions	b						
	B =	ner	if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	quence of):					
	ate be executed hysician and he burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c						
o o	e exe lan a urial-	Ĕ	resulting in death) Last	Due to (or as a conseq	quence of):					
3760,	ate b	ical		d						
89	leath certificat attending phy I for use as th	Med	15.55							
Box	h cer endir use	Z.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnancy			23d. Date of de	divery
	deat e att	icia	in the past 12 menths?	4☐Pregnant at time of d		Other (specify)			Month	Day Year
O.	at the de by the a tached	Physician/Med	9 □ Unknown	9□ Unknown				,		
٥,	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	by Р	Part If. Other significant conditions of	ntributing to death but not res	sulting in the und	derlying cause give	en in Part I.	23e. Did tobac	cco use contribute t	o the cause of death?
ğ	n sig		Diabetes	Mellity				1 ☐ Yes	2 No 3 P	robably 4 Donknown
00	w require been si should I	Completed						24a. Was an	24h Were a	utonsy findings available
Re	The tay page 2	mc						autopsy	prior to death?	utopsy findings available completion of cause of
<u>a</u>			25. Was case referred to medical						No 1 ☐ Ye	s 2 PNo
₹		o Be	examiner?	Hospital:		3□ DOA Othe	26. Place of Death			
of Vital Records,		-	27. Manger of Death	1 ☐ Inpatient 2 🖸	ER/Outpatient 28b. Time of	30 004	4 Linusing Hom	e 5 Residence Bd. Describe how	e 6 Other (Spe	ecify)
Division	Attending Ph r death. ector: After th by the funeral	Certification:	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	28c. Injury Work	Yes 2 No	30. 20001120 11011	injury coccined	
<u>S</u>	l or Attendi after death. Director: A in by the fu	ica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At he	ome farm street			of Location (Etm.	at and Alumbas as C	ural Floute Number,
<u>></u>	lor A after Direct	irti	4 Homicide determined	building, etc. (Specif	(y)	et, ractory, office	20	City or Town, S	State)	urai Houle Number,
_	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Phy	reician: To the best of an in-	uniodes d=="	negured at 1		al al a - 15		
	Hos Fun fely	ledical	(Check only 2 Medical Exam	rsician: To the best of my kno iner: On the basis of examina	tion and/or inve	occurred at the time estigation, in my or	ie, date and place, ar pinion, death occurred	d at the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)
	thin the mple	Mec	29b. Signature and title of certifier	and manner stated.		29c. License			. Date signed (Mon	
	5 1 2 1 2 E		101-1040)	. Date signed (MOII	on, Day, 18al)
			1 am & vine	wa_		20	021730		1.09	-04.
	U		30. Name and address of person who c		n 23a) (Type, P	rint)	11 1 .	1		
	<u>'</u>			Hat N mo		sinou	HESpita	<u> </u>		
×	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	Apa	els	-			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 200 4 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day nolerson Month Year 2:05PM **Physician** race 200 anuari /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner n/a imore zabeth rsing enter If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 29 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** 90 Days Hours Months 1 ☐ M 2 🗓 F Maryland Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a, State 10b. County or itama 23a or 28a-f show other traumatic avent, the Medical Examiner must be notified at 1 TYes 2 □ No Md. Completed by Funeral Director n/a **Baltimore** 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21227 U.S.A. 3310 Benson Ave. Apt. 227 death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 XWidowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Mail Order House Manager 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill ment of Health and Mental Hy lant: If item 27 Is marked oth Jeannette Kv1e Charles G. Price 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 437 W. Maple Road, Linthicum, Md. 21090 Evelyn B. Collins (Dgt.) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of H Important: If its any injury or of 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 01/17/04 Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility. ACCUITY Polyniak Funeral Home p.A. m00922 237 E. Patapsco Ave. Baltimore, Md. 21225 23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart-failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Nee elimonia Physician /Medical Due to (or as a cons quence of): Examiner month or Sequentially list conditions, if any, leading to immediate cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 menths?
1 Yes 2 No 3 Ectopic pregnancy Year Month Day 5 Other (specify) signed by the at the detached for 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 4 Dunknown ev 3 Probably 1 ☐ Yes 2 ☐ No YON 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform has page 2 certificate 1 ☐ Yes 2/2/No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Hospital: Other: 1 Ursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No М death. Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide hours after n 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the within 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

15altimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

6

3

			1 - For State Registrar	State of Man		artment of H				04 00697
	Physici /Medio	cal	1. Decedent's Name (First, Middle, Last	ALST	70N	45 C'5 T	al continue of S	2. Date of Dea Month	B, 20	Year 5:12 PM
	Examir	er	4e, Fecility Name (If not institution, give DHUS HOPKUS BAYM 5. Social Security Number 6. Se	EW MEDICAL	CEMER	BAZTIL If Under 1 Year			4c. County of	
	Funeral Director			ZM 2□F 2:	V	Months Days	Hours Mir	6. (Month, Day 8-22-8	y, Year)	Country) Md
	e Marylan 8a-f show	Director	Md. NA	11	Oc. City, Town or Lo Balt	imore				10d. Inside City Limits 1 Yes 2 No
	h with th	al Dire	10e. Street and Number 4909 Truesdale A	ve.		10f. Zip Code 21206			10g. Citizen of Wh USA	hat Country?
920	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "natural", or items 23e or 28e-f show event, the Madical Experience and the published.	by Funeral	11. Marital Status 1. Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 25 No If Yes, Give Year or Dates:	1	Vas Decedent of H f Yes, specify Cub	an, Mexican, Pue	Specify Yes or No- erto Rican, etc.)		- American Indian, , White, etc. Black
Maryland 21215-0036		Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		(Give	lent's Usual Occup kind of work done DO NOT use retire Derer	during most of w		16b. Kind of Busi	on Worker
rland 2	should be filed and Mental Hygid is marked other aumatic event, II	To Be Co	17. Father's Name (First, Middle, Last) Arthur	Tho	omas	1913	18. Mother's Na	ame (First, Middle,		icks
Mary	nd 2 shoulth and N 27 is ma		19a. Informant's Name/Relationship (T) Sitra Proctor	ype, Print) Aunt				Rural Route Numbe		tate, Zip Code) 222
Baltimore,	E E E		20a. Method of Disposition 1 Burial 2 Cremation 3 1 4 Donation 5 Other (Specify,	Removal from State	20b. Place of Dispo	and the last of th	ce)	Date		ity or Town, State
Balti	permit. Pages : Department of H Important: If ite eny injury or ot gnce.		21. Signature of Euneral Service Licens	Levi	1	Name and Addre	I. East	1101 E.	imore, M North Av	d. 21202
8760,	cate be executed Wedgical physician and the burial-transit	dicai Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of limits and the condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ine cause on each line.	VSTS Consequence of): (MWW onsequence of):	4RIN11	PNEUM			Approximate Interval Batween Onset and Death
.O. Box 6	that the death certifics ed by the attending pt detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 [4 ☐ Pregnant at tim 9 ☐ Unknown	Fetel death 3	Ectopic pregnanc	у		23d. Date Month	
rds, P	w requires that been signed to should be deta	by	Part II. Other significant conditions co	ntributing to death but r	not resulting in the ur	nderlying cause giv	ven in Part I.	23e. Did to		oute to the cause of death?
of Vital Record	The law ate has b page 2 sl	Completed						24a. Was a autop perfor	sy price dea	ere autopsy findings available or to completion of cause of ath?
	Attending Physician: Th r death. ector: After this certificate by the funeral director, pag	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manne of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: npatient 28a. ate Injury (Month, Day Y	2 ER/Outpatien 28b. Time of Injury	28c. Injur Wor	ner: 4 🗆 Nursing	Home 5 Resid	1011	
Division	in Diffe	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (- At home, farm, stre Specify)	eet, factory, office		28f. Location (S City or Tow	treet and Number n, State)	or Rural Route Number,
1	the Hospital nin 24 hours a the Funeral i	edical	29a. Certifier (Check only one) 2 Medical Exam	rsician: To the best of ri iner: On the basis of ex and manner stated	amination and/or inv	occurred at the til restigation, in my o	me, date and place opinion, death occ	ce, and due to the courred at the time, of	ause(s) and mann date and place, and	ner as stated. d due to the cause(s)
)	To the I within 2 To the I Complet	Me	29b. Signature and title of certifies	n our		29c. Licens	e number			Month, Day, Year) 4 13, 2004
			30. Name and address of person who c	ETEN AL	TELLE,	BAZTI	MORE	-	u) z	1224
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's 20\$4	Manature	4 Social	8)			

CHARLES ALCARAZ JR. 04-00156 RKD

1. Decedent's Name (First, Middle, Last) Charles						giene Reg. No. 2		and the same of
Charles					2. Date of Dea Month		Year	3. Time of Death
	Alc	araz, J	r.		JANUARY	•	2004	2.41P M
4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town,	or Location of Deat		4c. Co	ounty of Death	
1002 BELL AVE			GLEN E			ANN	E ARUNI	OEL
5. Social Security Number 6. Sex	714 000	yrs. last birthday)	If Under 1 Year Months Days		(Month, Day	h v, Year)	9. Birth	place (State or Foreign ntry)
430-01-3303	ZIVI Z	28 Yrs.			MAY	<u>27, 1</u>	.975 W	ashington
Usual Residence of Decedent 10a, State 10b, County	100	c. City. Town or Lo	ecation					10d. Inside City Limits
		•						1 ☐ Yes 2√E No
	ilde! (JIEH DULI	1			10a Citima	- of 14/hat Cau	
							n or writer Cou	nuyr
	2 Was Danadast Eves	in 11 S 12 1		Hispania Osigin? (C			Page - Ameri	can Indian
	Armed Forces?	In U.S. 13.	f Yes, specify Cub	pan, Mexican, Puer	o Rican, etc.)	14.	Black, White,	
	If Yes, Give 🗥		1□Yes 2∏No	Specify:		Sp	pecify:	White
		16a, Dece	dent's Usual Occur	nation		16h Kind	of Rusiness/In	
(Specify only highest grade	completed)	(Give	kind of work done DO NOT use retire	during most of world)	rking	TOD. KING	01 203/1033/11	idustry
	College (1-4or 5+)			,		Reta	il	
17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle,			
Charles Zavala Ale	oroz Cr			Sun Nom	Chone		,	
	,	19h Mailin	on Address (Street			r City or To	oum State Zin	Codal
								10-1
					- Conspine			
1 ☐ Burial 2 ☑ Cremation 3 ☐R							•	
							ımore,	MD
21. Signature of European Service License	ize	22	L Name and Addre	Society	of MD,	Inc.		
			199 Frede	erick koa	d Rait	<u>lmore</u>	, MD 2	21228 Approximate
resulting in death)	Due to (or as a cor	nsequence of):						
IF FEMALE: 23h Was decedent preparat.	3c. If yes, outcome of pr	egnancy				23d.	. Date of delive	ery
in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown				У			Month	Day Year
Part II. Dther significant conditions con	tributing to death but no	t resulting in the ur	nderlying cause giv	ven in Part I.	23e. Did to	bacco use	contribute to th	ne cause of death?
DIABETES MELLITUS.SE	TZURE DISORDE	R			1 □ Y	es 2 🗆 N	lo 3□Prob	ably 4 Unknown
,					24a Wasa	n 2	Ah Wara auto	nev findinge available
					autops	sy med?	prior to cor death?	mpletion of cause of
OF Was assessed to madical							1 X Yes	2 No
examiner?	ospital:		O#	206		-		
1 M 182 2 140	1 Inpatient		C 3 DOX	4 🗆 Nursing n				y) SCEINE
XXNatural 5 Pending	(Month, Day Yea	injury	Wo	rk?	20d. Describe III	OW IIII GIY OC	curred	
2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (Sp.	At home, farm, stropecify)		,103 2 110	28f. Location (Si City or Town	treet and No n, State)	umber or Rura	l Route Number,
29a. Certifier (Check only one) 1☐ Certifying Phys 2☑ Medical Examin	ician: To the best of my er: On the basis of exar and manner stated.	knowledge, death mination and/or inv	occurred at the til restigation, in my c	me, date and place opinion, death occu	, and due to the carred at the time, d	ause(s) and ate and pla	d manner as st ice, and due to	rated. the cause(s)
29b. Signature and title of certifier			29c. Licens	se number	2	9d. Date si	gned (Month,	Day, Year)
I him hi.	m. j		O.C.	M.E.	,TZ	MUARY	7.200	4
30. Name and address of person who co-	noleted cause of death	(Item 23a) (Tyne				,,	, 200	-
LING LI. M	()	5		Street,	Baltimo	re, Ma	aryland	21201
	Maryland Anne Aru Maryland Anne Aru 10e. Street and Number 370 Dublin Drive 11. Marital Status 1 Never Married Anne Aru 1 Never Married Anne Aru 1 Never Married Anne Aru 1 Never Married Anne Aru 1 Never Married Anne Aru 1 Never Married Anne Aru 1 Never Married Anne Aru 1 Never Married Anne Aru 1 Never Married Anne Aru 2 Married Anne Aru 1 Never Married Anne Aru 1 Never Married Anne Aru 2 Married Anne Aru 1 Never Married Anne Aru 1 Never Married Anne Aru 2 Married Anne Aru 1 Never Married Anne Aru 1 Never Married Anne Aru 1 Never Married Anne Aru 1 Never Married Anne Aru 1 Never Married Anne Aru 1 Never Married Anne Aru 1 Never Married Anne Aru 1 Never Married Anne Aru 2 Never Married Anne Aru 2 Never Married Anne Aru 2 Never Married Anne Aru 2 Never Married Anne Aru 2 Never Married Anne Aru 2 Never Married Anne Aru 2 Never Married Anne Aru 2 Never Married Anne Aru 2 Never Married Anne Aru 2 Never Married Anne Aru 2 Never Married Anne Aru 2 Never Married Anne Aru 2 Never Married Anne Aru 3 Never Married Anne Aru 4 Dororca 2 Never Married Anne Aru 2 Never Married Anne Aru 3 Never Married Anne Aru 4 Never Married Anne Aru 5 Never Married Anne Aru 5 Never Married Anne Aru 5 Never Married Anne Aru 6 Never Married Anne Anne Aru 7 Never Anne Anne Anne Anne Anne Anne Anne An	10a. State 10b. County Maryland Anne Arundel 10e. Street and Number 370 Dublin Drive 11. Marital Status 1	10a. State	100. County Maryland Anne Arundel Glen Burnie	Mary Indian Anne Arundel	10a. State 10b. County 10c. City, Town or Location 10c. Street and Number 370 Dublin Drive 10c. Street and Number 370 Dublin Drive 12 Was Decedent Ever in U.S. 13 Was Decedent of Historic Origin? (Specify Yes or No. In Yes, Street Judson, Marcial Dublin Drive 12 Was Decedent Federal U.S. 13 Was Decedent of Historic Origin? (Specify Yes or No. In Yes, Street Judson, Marcial Dublin Drive 15. Decedent's Education 15. Decedent'	106. Clays 107. County 108. Clays 109. Clays 10	10. Size 100. Columy Anne Arundel 10. Celly, Town or Location

			For State Registrar	State of Marylar		partment of Hea ertificate of De		ental Hygie Reg.	7001	00699
	Physicia	an	1. Decedent's Name (First, Middle, Las	it)					path Year	3. Time of Death
	/Medic	al	DAISY G. At 4a. Facility Name (If not institution, give	MBURN		4b. City, Town, or Lo	ecation of Death	JUNTINEA 1	4. 2004 4c. County of Dea	4.35 A M
	Examin	er	Northwest Hospital	street and number)		Randalsto			Baltim	
Ī	Funeral Director		Social Security Number 6. S	9x 7. Age (<i>ln yr</i> s.	last birthda Yrs.	y) If Under 1 Year If	Under 24 Hrs	8. Date of Birth (Month, Day, Ye November 30	0.00	thplace (State or Foreign ountry) ^G1111a
	put 3		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or	Location				10d. Inside City Limits
	Maryis -f shor	to	Maryland Baltimo		altimor					1 ☐ Yes 2 ☐ No
	with the a or 28a	Director	10e. Street and Number 6811 Campefield Road			10f. Zip Code 21207			Citizen of What C	ountry?
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Heatth and Mental Hygiene. If item 27 is marked other than "neturel", or items 23a or 28a-f show or other traumatic event, It is Medical Examinational be rediffed at	y Funerai	11. Marital Status 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	.S. 13	3. Was Decedent of Hispa If Yes, specify Cuban, N	anic Origin? (Spe Mexican, Puerto i Specify:		14. Race - Am Black, Whi	te, etc.
8	2 hour	ted b	15. Decedent's Ed	ucation	16a. Dec	cedent's Usual Occupatio	on	160	o. Kind of Business	
Maryland 21215-0036	vithin 7; ne. han "ne	Completed by	(Specify only highest gra	de completed) College (1-4or 5+)		ve kind of work done duri DO NOT use retired)		ng	T	
2	filed w Hygier ther ti		17. Father's Name (First, Middle, Last)	2	1	nsurance Clerk		(First, Middle, Mail	Insurano den Sumame)	ce
au	should be ind Mental in marked o	To Be	Robert Lee Amburn				Bettie Lou		,	
ary	2 shou and N is mar		19a. Informant's Name/Relationship (7			illing Address (Street and				
S O	tealth		Mrs. Robert W. Amburn			O Haywood Drive			/land 2090 :. Location - City of	
nor	ages int of h		1 X Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specify	neilloval ilolli State		position (Name of rematory or other place) em. Gardens	1/17/			
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licen	seeChristina L. Hi			of Facility	VI. 1474	Oublin, Vir	vinia
<u>m</u>	8888		Chustina (Xtelton		22. Name and Address of Leopard J. Ruc 5305 Harford R		imore Maryla	and 21214	
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final	_	h. Do note EPSI		such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a conseq						
	Examiner	-	Sequentially list conditions,	b. GAST	RO IN	MITESTIMA	L BLE	60		
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
60,	ificate be executed g physician and as the burial-transit		resulting in death) Last	Due to (or as a conseq	uence of):					
68760,	ificate g physias the	edicai		d						
.O. Box	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use as	Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 N No 9 ☐ Unknown	23c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of constitution of the properties of the pregnant at time at the pregnant at time at time at time at the pregnant at time at	il death 3	B⊟Ectopic pregnancy □ Other (specify)			23d. Date of de Month	livery Day Year
rds, P.	quires that n signed b	d by PI	Part II. Other significant conditions co	ontributing to death but not res	ulting in the	underlying cause given i	n Part I.	23e. Did tobace		o the cause of death?
Division of Vital Records,	The law require sate has been si page 2 should I	Complet						24a. Was an autopsy performed 1 Yes 2	prior to death?	utopsy findings available completion of cause of 2 No
Z Z	certific rector	Be	25. Was case referred to medical examiner?	Hospital:		04		(Check only one)		
n of	Attending Physicien: if death. ector: After this certification in the funeral director.	lon; To	1 ☐ Yes 2 1 No 27. Manner of D ath 1 Natural 5 ☐ Pending	28a. D te of injury (Month, Day Year)	ER/Outpati 28b. Time Injury	of 28c. Injury at Work?	2	ne 5 ☐ Residence 8d. Describe how i		cify)
Divisio	afte Ti Dir	Certification:	2/□Accident investigation 3 □ Suicide 6 □ Could not be 4 □ Homicide determined		ome, farm, : y)		s 2 □ No 2	8f. Location (Street City or Town, S.		ural Route Number,
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical C	29a. Certifier (Check only one) 1 Certifying Ph	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, de	ath occurred at the time, investigation, in my opinion	date and place, a on, death occurre	nd due to the cause od at the time, date	e(s) and manner a and place, and due	s stated. e to the cause(s)
	To the within To the complete	Me	29b. Signature and title of certifier	n-elta m.o	1	29c. License nu	umber 41410		Date signed (Mon	th, Day, Year)
	1		30. Name and address of person who					MEHTA	/ /	1
	1		MINTH WEST	HUSPITAL C	ENTE	A RANG	MLS TO		0 211	33
	Sta Registr	- 1	31. Date filed (Month, Day, Year) JAN 15 200	4 32: Registrar's Signa	ture	and .				

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Josephina Alvarina lanuary 13 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore City N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 219-40-2713 99 Director 20,1904 Feb. Spain Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show rthan "natural", or Itams 23s or 28e-f show the Medical Examinar outs to could be Mary land N/A Baltimore City 1 Yes 2 □ No Funeral Director 10e. Street and Number 3406 Parkside Drive 10f. Zip Code 10g. Citizen of What Country? 21214 Spain 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 X Yes 2 No Specify: Senon White Specify: à 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other treumatic event, the Me 90cs. Elementary/Secondary (0-12) UNKNOWN College (1-4or 5+) Housewife. Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be Francisco Rodriguez Carmen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Lisa Raynor - Daughter 3406 Parkside Drive Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Jan. 17,2004 Baltimore, MD * 4 □ Donation 5 □ Other (Specify) permit. 21. Signature of Funeral Service License 22. Name and Address of Facility Baltimore, Maryland 21214 Hen Leonard J. Ruck, Inc. 5305 Harford Rd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician real /Medical **Examiner** Sil Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Physician/Medical as attending p IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) ed by the a detached f Part II. Other significant conditions contributing to death but not restiting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death2 Division of Vital Records, þ ulmo 3 ☐ Probably 4 ☑ Unknown been signature 1 ☐ Yes 2 ☐ No. Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has certificate ha autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No Hospitel or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To funeral 27. Manner eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Cantural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours To the Funerel 29a. Certifie 1 Zertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARTORD SPACI 1 41 31. Date filed (Month, Day, Year) 32. Registrar's Si State Registrar

State of Maryland / Department of Health and Mental Hygiene State
Registraamend item #2 PFR DVR G827 1/15/04 Jartificate of Death 1. Oecedent's Name (First, Middle, Last) 2. Date of Death 2004_{eer} 3. Time of Death **Physician** JANUARY 13, 2003 SOPHIE 6:43 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Oeath 4c. County of Deeth Examiner CHERRYWOOD NURSING HOME REISTERSTOWN BALTIMORE 5. Social Security Number 082-12-1887 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) JAN. 18, 1903 6. Sex Birthplace (State or Foreign Country) **Funeral** 1□ M 2 F 100 POLAND Director Usual Residence of Oecedent the Maryland 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 28a-f show ed other then "natural", or Items 23a or 28a-f show event, the Medical Examinat must be notified at 1 ☐ Yes 2 ☑ No BALTIMORE **UPPERCO** Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3228 MT. ZION ROAD 21155 U.S.A. death Funerai 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: Completed by WHITE 3 ☐ Widowed 4 💢 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FUR FINISHER GARMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be of Health and Mental item 27 is marked or r other traumatic eve **I SRAEL** HABER **ESTHER** 2 BLAU 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BERNARD KIRSCHNER / SON 3228 MT. ZION ROAD - UPPERCO, MD 21155 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) MIKRO KODESH BETH ISRAEL 1/14/04 BALTIMORE, MD 22. Name and Address of Facility 21. Signature of Funeral SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician /Medical resulting in death) Due to (or as a consequence of Examiner CORDN Esquantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit Respital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical ed by the attending detached for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Tes 2 S No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MONDEY 1JEAN 1 Tyes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 Yes 2 □ No 1 ☐ Yes Be 25. Was case referred to medical examiner? director 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient Other: 4 🗹 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) ٩ 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury 28c. Injury at Work? 28d. Oescribe how injury occurred Certification: After 5 Pending investigation 1 Matural 1 ☐ Yes 2 Accident after death Director: / 6 Could not be determined 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide i 24 hours aft e Funeral Di letely filled in 29a. Certifier 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1/13/04 30. Name and address of erson who completed cause of death (Item 23a) (Type, Print) BACTIMORE Red. SADOWIK 1833 MD 21208 MIGUEL

State

Registrar

31. Date filed (Month, Day, Year)

Registrar's Signature

5

			State of Maryle	and / Denartme	ent of Health and	Mental Hygiene	acgibic.
		1. For State Amend Item	State of Maryla 7 per FH, G84	45,07/28/05d	hb ite of Death	Reg. No	2004 00702
	10	1. Decedent's Name (First, Middle, Las	st)	· ·		2. Date of Death	3. Time of Death
Physic		(500 90R4	1 . +	Srisco	e	January Da	12 2004 845 AM
/Mec Exam		4a. Facility Name (If not institution, give	street and number)	4b. Cit	y, Town, or Location of Dea		. County of Deeth
		VIIIa 51.	Michae	2	to altim	ore	NIH
Funera	1	5. Social Security Number 6. S		Month	s Days Hours Min	8. Date of Birth	Birthplace (Stete or Foreign Country)
Directo	r	619-62-1281	M 20F	Yrs.	34,5	08/05/1955	MI)
pu *		Usual Residence of Decedent 10a. State A 10b. County	10c	City, Town or Location			10d. Inside City Limits
sho	5	MD	114	Poc	Itima	2)	1X Yes 2 □ No
he N	ect	10e. Street and Number		101	Zip Code	10g Cit	izen of What Country?
q 21215-UU36 filed within 72 hours after death with the Maryland Hygiene kther than "natural; or itema 23a or 28a-f show ant, the Madical Experiment matter notified at	Funeral Director	510111	2 CONCER O	ST	7100	7	$II \leq \Delta$
leath	678	11. Marital Status	12. Was Decedent Ever in	n U.S. 13. Was Dec	cedent of Hispanic Origin? (Specify Yes or No-	14. Race - American Indian,
fter d	臣	1 Never Married 2 Married	Armed Forces? 1 Tyes 2 Tho If Yes, Give	If Yes, s	pecify Cuban, Mexican, Pue	to Rican, etc.)	Black, White, etc.
U36	þ	3 □ Widowed 4 □ Divorced	If Yes, Give / Year or Dates:	1 ☐ Yes	2 No Specify:		Specify: Black
5-C	Completed	15. Decedent's Ec (Specify only highest gra		16a. Decedent's U:	sual Occupation work done during most of wo	16b. K	ind of Business/Industry
27275-0036 d within 72 hours af giene or than "natural; or	d	Elementary/Secondary (0-12)	Coltege (1-4or 5+)	life. DO NOT	use retired)	5	PARROWS
d 21 filed wi Hygien other th	S	12		Las	UKEK		Point
land id be file ental Hy ked oth ic event	Be	17. Father's Name (First, Middle, Last)	7	2	18. Mother's Na	me (First, Middle, Maiden	Sumame)
arylan should be ind Mental marked o	은	HIBERI	Drisco	e	ha!	10nia,	DHVIZ
Maryi d 2 shoult th and Me ?7 Is mark traumati		19a. Informant's Name/Relationship	1/1/1	196. Mailing Addre	ss (Street and Number or R	- R	or Town, State, ap Code)
1 and 2 Health Health tem 27	1	20a. Method of Disposition	c VV horter	b. Place of Disposition (A	lame of	Date 20c I	ocation - City or Town, State
timore, it. Pages 1 ar itment of Hea itant: If item		1 Burial 2 Cremation 3	Removal from State	cemetery, crematory o	r other place)	5-04 N	MARULAND
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23a or 28a-1 show eny injury or other traumatic event, the Madical Experiment vinal by notified at	<u>.</u>	4 □Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		22. Name	and Address Facility	HIND IT	1100000 Histor
Balt permit. Departr Imports eny inju		MILLINES	Jan 1000	2/ Hear	1 20 1	ALL Ra.	70 Mp 21307
WILLIAM STATE		23a. Part1. Enter the disease, or com	plications that caused the d	leath. Do not enter the m	ode of dying, such a cardia	c or respiratory arrest,	Approximate
District Co.		shock, or heart faiture. List only tmmediate Cause (Final	one cause on each line.		and the second	a / 1= 1	Interval Between Onset and Death
Physiciar /Medica	_	disease or condition resulting in death)	a. Due to (or as	sequence of	Justa	Mets to	ran
Examine	r		4.1	- Aid	<		
	ية ا	Sequentially list conditions, if any, loading to immediate cause. Enter Underlying	Due to (or as a con	sequence of	_		
cuted nd ransif	Examin	that initiated events	· Heser	145 C	<u>.</u>		
760, te be executed ysician and te burial-transit		resulting in death) Last	Due to for as a cons	sequence of):			
	Ilcai		d				
K 68 artifica ling phi	Physician/Med	IF FEMALE:					
BOX sath cert attendin	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre	etal death 3 Ectopic		10	23d. Date of delivery Month Day Year
the de sy the a	/sic	1 Yes 2 No	4 ☐ Pregnant at time of 9 ☐ Unknown	of death 5 Other	(specify)		,
d bat	F	Part II. Other significant conditions of	contributing to death but not	resulting in the underlying	cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
Records, he law requires t e has been signe age 2 should be o	d by		J	, ,	•	1 ☐ Yes 2	
COrd w requir been si should	Completed					24a. Was an	24b. Were autopsy findings available
He lav	E G					autopsy performed?	prior to completion of cause of death?
al I		25. Was case referred to medical				1 Yes 2 No	
of Vital Rec Physician: The law this certificate has trail director, page 2 s	o Be	examiner?	Hospital:	2 ER/Outpatient 3	0.1	ath (Check only one)	o Flour (c. 11)
Of Phys		27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury at	Home 5 Residence	
Division of lor Attending Phy after death. Director: After this din by the funeral d	ţ	1 ✓ Natural 5 ☐ Pending investigation	(Month, Day Yeer	r) Injury M	Work? 1 ☐ Yes 2 ☐ No	,	
DIVISION or Attending after death. Director: After in by the fune	ifica	3 ☐ Suicide 6 ☐ Could not be determined	289. Place of Injury - A	At home, farm, street, fact	ory, office	28f. Location (Street ar	nd Number or Rural Route Number,
al or all Direction of in the	Certification:	4 🖸 Homicide	building, etc. (Spe	өспу)		City or Town, State)
Division of Vital Re To the Assplat or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	ai	29a. Certifier Certifying Ph	ysician: To the best of my	knowledge, death occurre	ed at the time, date and place	e, and due to the cause(s	and manner as stated.
n 24 he Fr	Medical	(Check only 2 Medical Examone)	and manner stated.	nination and/or investigati	on, in my opinion, death occ	urred at the time, date and	d place, and due to the cause(s)
To the within 2 To the	Σ	29b. Signature and title of certifier		2	29c. License number	29d. Da	te signed (Month, Day, Year)
1		Wine B	32,	nd .	DV5-421	- 1/1	1704
7		30. Name and address of person who	completed cause of death (Item 23a) (Type, Print)	. /	- 211	2:11
1		Wille BMVEL	LBA, MI)	413 Corni	usiveal	e AV cax	susville ell 21228
S	tate	31. Date filed (Month, Day, Year)	32. Reputirar's Si	ignature	20		/

			For State Registrar	State of Marylar	-	ent of Health and I	Mental Hygie	6004	00703
	Physicia /Medic	an	1. Decodent's Name (First, Middle Las	FOCKIN	Gton		2. Date of Death Month Junuary	Day Year 7004	3. Time of Death 2:45 A M
	Examin Funeral Director	er	4a. Facility Name (If not institution, give Strat Hospital of 5. Social Security Number 6. Se 417 64-9373	Baltimore	Bot last birthday) If Und	ty, Town, or Location of Death LINEWY City der 1 Year If Under 24 Wis. s Days Hours Min.	8. Date of Birth (Month, Day, Yo	9. Birth	place (State or Foreign
Brockington	p	ctor	Usual Residence of Decedent 10a. State 10b. County	A 10c. Ci	ty, Town or Location	imore			10d. Inside City Limits NYes 2 □ No
vckir	ath with the 23a or 2	ral Dire	4501 Hom	<u> </u>	-	21215		Citizen of What Con	
୍ ଫ	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Madical Examiner must be notified at	d by Fune	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces?/ 1 Yes 2 No If Yes, Give Year or Dates:		cedent of Hispanic Origin? (S pecify Cuban, Mexican, Puert 22 No Specify:	o Rican, etc.)	Black, White	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at	Completed by Funeral Director	15. Decedent's Ed (Specify only highest grau Elementary/Secondary (0-12)	ucation de <i>completed)</i> College (1-4or 5+)	16a. Decedent's Us (Give kind of life. DO NOT	work done during most of wor use retired)	king	o. Kind of Business/I	. tic
S P	should be filed within and Mental Hygiene. marked other than matic event, the Mental Country of the Mental Cou	To Be (17. Father's Name (First, Middle, Last)	itchel		MA	1	1.14	
	1 and 2 sho Health and tem 27 is m		James Bro	Kinyton	4906 E	ess (Street and Number or Ru	BaITO	MD 2	407
Patient & Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	Place of Disposition (Accemetery, crematory of	(watery 01-	Date 200	. Location - City or T	land
Pat Ball	permit Depart Import any in		21. Signature of Funeral Service Licen	e towers	1460	and Address of Facility H	John B	all in	10mc
•	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consect	a	ode of dying, such as circliad	or respiratory arrest		Approximate Interval Between Onset and Death
	Examiner	Iner	Sequentially list conditions, I arry, leading to immediate cause. Enter Underlying	b. Sepsis					
760,	ate be executed hysicien and the burial-transit	Icai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consected.	quence of);				
P.O. Box 68	The law requires that the death certificat ate has been signed by the attending phy page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 ☐ Ectopic			23d. Date of delimenth	very Day Year
ds, P.	uires that I signed by Id be deta	ρ	Part II. Other significant conditions of	ontributing to death but not re-	sulting in the underlying	g cause given in Part I.		co use contribute to	. /
Vital Records,	: The law require cate has been sig , page 2 should t	Completed					24a. Was an autopsy performe 1 ☐ Yes 2 ☑	d? death?	topsy findings available ompletion of cause of
of Vita	Physicien: Th this certificate al director, pag	To Be	25. Was case referred to medical examiner? 1 Tyes 2 No		ER/Outpatient 3	DOA Other: 4 Nursing H	ath (Check only one)	e 6 ⊡Other (Spec	ıfy)
Division o	ding h. Afte fune	Certification:	27. Mannar of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		28b. Time of Injury M	28c. Injury at Work? 1 Tyes 2 No	28d. Describe how		
Divis		Certifi	4 Homicide determined	building, etc. (Speci	ify)		City or Town, S		
N	To the Mospitel or within 24 hours afte To the Funerel Dir completely filled in	edical (29a. Certifier 1 Check only 2 Medical Exam	ysician: To the best of my kn niner: On the basis of examin and manner stated.	owledge, death occurr ation and/or investigati	ed at the time, date and place ion, in my opinion, death occu	o, and due to the caus irred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the To the Complete	Σ	29b. Signature and title of certifier	Imib.		RES - 000		Date signed (Month	Day, Year)
	3		30. Name and address of person who	1		Hospital of E	Baitimore	2	
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's 9	alure	last.			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Year William Patrick Blockinger January 09 2004 23 45 PM 4a Fecility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death St. Agnes Hospital Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1**∑**M 2□ F Months 218-30-7389 Usuel Residence of Decedent 68 MAR 17, 1935 Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 1₽ Yes 2□ No Maryland N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 516 Lakewood Avenue 21224 USA 12. Was Decedent Ever in U,S. Armed Forces? 11. Maritel Status Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give △ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give -Year or Dates: Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) Truck Driver 6 Moving Company 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Blockinger Thomasine Metzler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Blockin er/Son 3951 Brooklyn Avenue Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 1-14-04 21. Signature of Finer II Service July 19 Baltimore, MD 22. Name and Address of Facility Cremation Society of ND. Edward A. Inc. & regorchik 299 Frederick Road Baltimore, MD 21228 23a. Pert1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) iration Sequentially tist conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as e consequence of): Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? ZLINO 1 Yes 2 No 1 X Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital:

Physician /Medical Examiner or Attanding Physician: The law requires thet the death certificete be executed

Physician

/Medical

Examiner

Directo

Funeral

2

Be Completed

Funeral

Director

permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Meryler Depertment of Health end Mentel Hygiene. Important: If Item 27 is merked other than "natural", or freme 23s or 28s-f show any injury or other traumatic avant, the Medical Examiner mant be notified as

Blockinger,

Physician/Medical Examiner Medical Certification: To Be Completed ours efter death.

eral Diractor: After this certifica filled in by the funerel director,

Division of Vital Records, P.O. Box 68760.

δ

1 ☐ Yes 2 No

29a. Certifier

27. Manner of Death 1 Naturat
2 Accident 5 Pending investigation 3 ☐ Suicide

6 Could not be determined 4 ☐ Homicide

1 Danpatient 2 ER/Outpatient 3 DOA 28b. Time of

(UI)

28c. Injury et Work?

1 Yes 2 No Plece of tnjury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1AC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D0056143 29d. Date signed (Month, Day, Year)

30. Name and address of berson who completed cause of death (Item 23a) (Type, Print) 900 CATON AVE. BALTIMORE, MD21229 W. RAYMOND ZHU.

31. Dete filed (Month, Day, Year)

JAN 1 5 2004

Registrar's Signature

State Registrar

To the Hospital or within 24 hours eff To the Funeral Di completely filled in

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Dev **Physician** Month Year 10:30AM AZEL ENTUN Januar 2004 /Medical 4a Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Dee Examiner HARBUR HUSPITAL n/a ENTER TIMORE If Under 24 Hrs. If Under 1 Yeer 5. Sociel Security Number 7. Age (In yrs. lest birthday, 8. Date of Birth (Month Day, Year) Jan. 08 1921 9. Birthplace (State or Foreign **Funeral** Days Hours Months 218-07-0145 1 M 2 F 83 Yrs. Maryland Director Usuel Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours efter death with the Maryland Depertment of Health end Mental hygiene. Important: if item 27 is marked other than "natural", or heme 23s or 28s-f show any injury or other traumetic event, the Medical Evandher must be notified at 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Md. n/a Baltimore 1 Ves 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21230 503 E. Gittings Street U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Š Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Packer Knox Glass 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 Elsie John LaBarre Conway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) James W. Benton Sr. (Son) 758 E. Fort Ave. Baltimore, Md. 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location · City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 01/14/04 Baltimore, Md. 22. Name and Address of Fecility
McCully-Polyniak Funeral Home F.A.
130 E. Fort ave. Baltimore, Md. 21230 21. Signature of Funetal Service Licenses m00922 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock or heart failure. List only one ceuse on eech line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): 1mon Ra ettending physician end for use as the bunel-trensit The law requires that the death certificate be executed Exam Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of) ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 1 Yes 3 Probably 4 Unknown ģ After this certificate has been situneral director, page 2 should it Completed 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24a. Was an autopsy performed? 2 No 1 Tes 1 ☐ Yes 2 No or Attending Physician: 8 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1. Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Death 28b. Time of Certification: 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturel 5 Pending efter death. 2 Accident investigation 1 Yes 2 No Diractor 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rurel Route Number, City or Town, State) 4 T Homicide To the Mospital of within 24 hours of To the Funeral D completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1734 30. Name and address of person who completed sales of death (Item 23e) (Type, Print) AYDENU 3001 HANWER

State Registrar

31. Dete filed (Mortin 14 Year) 5 2004

DHMH 16 Rev 6/95

			1- State of M	aryland / De	epartmei <i>ertifica</i>	nt of Heate of De	alth and N eath		giene 2	004	00706
			Decedent's Name (First, Middle, Last)			_		2. Date of Dea	ith Day	Year	3. Time of Death
	Physicia /Medic		James Wesley Beall	_				Januar	-	2004	7:30 A M
À.	Examin		4a. Fecility Name (If not institution, give street and number)		4b. City	, Town, or Lo	ocation of Death		4c. Coun	ty of Death	
			15602 Bond Mill Road		La	urel			Prin	ce Geo	orge's
	Funeral			ge (In yrs. last birthd	Months		f Under 24 Hrs. Hours Min.	8. Date of Birti (Month, Day	Y. Year)	9. Birthp	place (State or Foreign
н	Director		214-30-2486 XX ^{M 2□F}	73 Yrs				Apr. 3,		Mar	yĺand
	and .		Usuel Residence of Decedent 10a. State 10b. County	10c. City, Town o	r Location						10d. Inside City Limits
	Aaryl r eho	ŏ	MD Prince George's								1 ☐ Yes 2 ☐ No
	28a-	Director	MD Prince George's 10e. Street and Number	Laurel		p Code			10g. Citizen o	f What Cou	XX
	with Ba or	₫	15602 Bond Mill Road			20707					,,
	na 2%	era	11 Marital Status 12. Was Decedent	Ever in U.S.	13. Was Dece		anic Origin? (Sp	pecify Yes or No- Rican, etc.)	U.S.A 14. Ra	ace - Americ	can Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other then "natural", or Itama 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral	Armed Forces: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes ② X X If Yes, Give Year or Dates:	No	If Yes, spo 1 ☐ Yes		Mexican, Puerto Specify:	Rican, etc.)		ack, White, hity: White	
21215-0036	2 hou	ted	15. Decedent's Education	16a. De	ecedent's Usi	al Occupatio	on .		16b. Kind of	Business/In	dustry
212	nin 72 n n	Completed	(Specify only highest grade completed) Elementary/Secondary (0·12) College (1-4or	(G	ive kind of w e. DO NOT i	ork done duri ise retired)	ing most of work	king			•
2	d with	E O	Elementary/Secondary (0-12) College (1-4or Grade 8	Tr	uck Dr	iver			Concr	ete Co	ompany
Maryland	at Hy I oth	Be	17. Father's Name (First, Middle, Last)			18	3. Mother's Nam	e (First, Middle,	Maiden Suma	ame)	
<u>a</u>	Ment Ment arked	2	Richard Edward Beall				Susie G	Gore			
an.	2 sho and ie ma		19a. Informant's Name/Relationship (Type, Print)	19b. M	ailing Addres	s (Street and	d Number or Rur	al Route Numbe	r, City or Tow	n, State, Zip	Code)
2	and ealth m 27	3	Elizabeth Beall / spouse					Laurel,			20707
ore	of H of H if ite.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Di cemetery, o	sposition (Na crematory or	me of other place)		Date	20c. Location	r - City or To	own, State
Ē	Pag ment ant: ury c		* 4 Donation 5 Dother (Specify)	Union C	emeter	У	1/ 13	3/2004	Burto	nsvill	Le, MD
Baltimore,	permit Depart Import any in		21. Signature of Funeral Service Licensee					Home, P. Laurel		land	20707
卷	70 38		23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each li	d the death. Do not							Approximate Interval Between
	Priysician		Immediate Cours (Final	pulmonary	Arres	+				4	Onset and Death
	/Medical		resulting in death)	a consequence of):	ALLES					_	
	Examiner	Sequentially list conditions, b. Metastatic Carcinoma of Rectum									
	D =	ner	if any, leading to immediate Due to (or as cause. Enter Underlying	a consequence of):							
	nd nd transi	Examiner	Cause (Disease or injury that initiated events c.								
Ö,	e exe sian a urial-		resulting in death) Last Due to (or as	a consequence of):							
8760	icate be executed physician and s the burial-transit	dlcal	d								
9	entific ling p	0	IF FEMALE:	4.							
Вох	the death certific y the attending p Iched for use as	by Physician/M		2 Fetal death	3 □Ectopic p					ate of delive	ery Day Year
0	the a	ysic	1 Yes 2 No 4 Pregnant a	I time of death	5 Other (s	oecity)					,
٦.	that the de led by the a detached t	P	Part II. Other significant conditions contributing to death b	out not resulting in th	e underlying	ause given ir	n Part I.	23e. Did to	bacco use cor	ntribute to th	ne cause of death?
Records,	The law requires that ate has been signed boage 2 should be deta			•					es 2□No		v
ပ္ပ	has be	Completed						24a. Was a autops	v	. Were auto	psy findings available inpletion of cause of
		Son						perfor	med? 2 🖾 No	death?	
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?				6. Place of Deat	h (Check only or	(e)		
6	Physic this c	၉	1 ☐ Yes 2 🛣 No Hospital: 1 ☐ Inpatie					me 5 X Reside			<i>'</i>)
n	on (fter	on:	27. Manner of Death 1 XNatural 5 Pending 28a. Date of Inju (Month, Da	iry 28b. Time ly Year) Injur		28c. Injury at Work?		28d. Describe ho	w injury occu	rred	
Sio	tend feath tor: /	cat	2 Accident investigation 3 Suicide 6 Could not be		М		2 No				
Division	or At	Certification;	determined 200. Flace of in	ury · At home, farm, c. (Specify)	street, factor	y, office		28f. Location (Si City or Town		ber or Rura	I Route Number,
_/	erel [29a. Certifier 1P. Certifying Physician. To the best	at may be constituted as a state		-141 414		NA VOLUM			
//	To the Hospital or Attending I within 24 hous after death. To the Funerel Director: After completely filled in by the funer	edical	29a. Certifier (Check only one) 1 Certifying Physician. To the basis of and manner st	r examination and/oi	r investigation	, in my opinio	uate and piace, on, death occurr	and due to the cared at the time, d	ate and place	ianner as st , and due to	ated. the cause(s)
	o the	Me	29b. Signature and title of certifier	7	29	c. License nu	umber	2	9d. Date sign	d (Month/	Day, Year)
)	- > H O		> / Jan / A Hom	X 170		200	217	5 2	1/	9/	4
	1()	1	30. Name an indiress of perion who completed cause of c	leath (Item 23a) (Tvi	pe, Print)	100	2010	111111111111111111111111111111111111111	-//	1/0	1
	U			Medical		rive #	211 64	luer Cr.	ina /	(D	
	Sta		31. Date filed (Month, Day, Year) 32. Registration	ar's Signature			71	TAGE SDI	THG. N	1D	
P.	Registr	ar	JAN 1 5 2004	see so	1	E.J					

			1 - For State Registrar	State of Marylan	-		of Health ar of Death		giene 200	4 00707
	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Last) Betty Lee Bowley 4a. Facility Name (If not institution, give s	2		4b. City, To	wn, or Location of I	2. Date of De Month January	Day Year	2:50 p M
4.5	Funeral Director	lei	Mariner Health Car 5. Social Security Number 6. Sex	re	last birthday) Yrs.	Laure	≘1 Year If Under 24		Prince (
more, marylan	Demit. Pages 1 and 2 should be littled within 72 hours after deeth with the Maryland Department of Health and Mental Higher Beat insportant; if item 27 is marked other than "natural; or Itams 23a or 28a-f show any injury or other traumatic event, the Madical Examinar must be notified at once.	To Be Completed by Funeral Director	Usuat Residence of Decedent 10a. State 10b. County MD Prince Ge 10e. Street and Number 7505 Sandy Spring 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade) Elementary/Secondary (0-12) Grade 12 17. Father's Name (First, Middle, Last) Wilson Keller 19a. Informant's Name/Relationship (Type Edward Paul Bowley 20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Los See	Road 2. Was Decedent Ever in U. Armed Forces? 1 Yes 2 2 No If Yes, Give Yes or Dates: action a completed) College (1-4or 5+) Dec. Print) 7 / Son emoval from State Ph:	16a. Deced (Give life. I 19b. Mailir 9613 1 lace of Dispo emetery, cren ilos Co	10f. Zip Co 20' Was Decedenif Yes, specify 1 Yes 2Cl deni's Usual Co DO NOT use r Omemake and Address (Si Norfol) sition (Name a natory or other	707 Tof Hispanic Origin Cuban, Mexican, F KNo Specify: Inccupation fore during most of elired) 18. Mother's Ruth Treet and Number of A Ave. I	17 (Specify Yes or No- Puerto Rican, etc.) If working S Name (First, Middle, 1 Raines	Specify: V 16b. Kind of Busines OWN Home Maiden Sumame) or, City or Town, State, Cyland 20 20c. Location - City or Western por	zip Code) 7723
	Chysician by Medical by Medical by Medical by Medical transit street prize transit street pri	Ical Examiner	23a. Part1. Enter the disease, or complice shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, heading to ammediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cations that caused the death e cause on each line. Pneumonia Due to (or as a consequence of the condent of t	n. Do not enter a uence of): Ve Hear dence of).	er the mode of	f dying, such a <i>s</i> ca	uue Laurel		Approximate Interval Between Onset and Death Days months Years
.O. BOX 68	notine hospital or Attenuing rrigstrant: The law requires that hearn certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 200000	3c. If yes, outcome of pregna 1 □Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	death 3	Ectopic pregn			23d. Date of de Month	olivery Day Year
colds, r	w requires ma been signed to should be det	þ	Part II. Other significant conditions cont Organic Brain Synd Pulmonary Embolus	lrome						o the cause of death? robably 4 Aknown utopsy findings available
יומו	s certificate has t lirector, page 2 s	e Completed	25. Was case referred to medical					autop:	sy prior to med? death? 2 ¹² No 1 ☐ Ye:	completion of cause of
A 10 11016	tending rinystician. The leath. for: After this certificate his the funeral director, page	Certification; To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	ospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c.	Other: 4XXVursi Injury at Work? 1 \(\text{Yes} \) 2 \(\text{No} \) No	ng Home 5 □ Resid 28d. De <i>s</i> cribe h	ence 6 Other (Spe	
	within 24 hours after deal within 24 hours after deal To the Funeral Director:		4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify ician: To the best of my known	<i>'</i>)			City or Tow		
/	vithin 24 hose nose to the Function of the Fun	Medical	(Check only 2 Medical Exeminone) 29b. Signature and title of certifier	er: On the basis of examinat and manner stated.	ion and/or inv	estigation, in i	my opinion, death o	occurred at the time, d	ause(s) and manner a late and place, and du	e to the cause(s)
·	12		30. Name and address of person who co	npleyed cause of death (Item	23a) (Type, I	Print)	D25422		January	13, 2004
324	Sta Registr		Robert Maggin, M.D 31. Date filed (Month, Day, Year)	. 13952 alt		Avenue	Laurel	, Maryland	20707	

State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 55/1 **Physician** /Medical 4b. City, Town, or Location of Death 4g. County of Death Examiner Mandallstonen
If Under 1 Year If Under 24 Hrs. 8. Date of mar 6. Sex 7. Age (In yrs. last birthday) (State or Foreign **Funeral** 12 Days 1 □ M 200 F O Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: if item 27 le marked other than "natural", or items 23s or 28s-1 show any injury or other treumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 ☐ No Director more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21244 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify 4 If Yes, Give (Year or Dates: 3 Widowed 4 Divorced BLAC 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Seçondary (0-12) GOVERNMENT ederal 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BACT. MOSE 21244 Barnum / Hisband Fmar 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Green Mount Cemetry 1-15-04 22. Name and Address of Facility Vaughn C. Greeke Foneral Services 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 8728 Liberty Rd Kandallstown 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 000 **Physician** /Medical **Examiner** Saquantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and thed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy page 2 should be detached for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2/2KNo 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes 2 ☐ No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Hatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) O VQ 32. Registrar's Signature 31. Date filed (Month, Day, Year) JAN 1 5 2004 Registrar

		1	For State Registrar	State of M		nd / Depa		t of H	ealth a		ental Hy		200	-	00	709
/M	/siciar ledica		Decedent's Name (First, Middle, La MARCHARET A. Facility Name (If not institution, give	JUN		BAIZ	THOU	LOW OF	Location o		2. Date of De Month	7 Cz		Yeer 204	3. Time	of Death
Fune			SHADY GROVE 5. Social Security Number 6.5	. ADVENT	51 1	HUSPITAL last birthdey) Yrs.	1200	IZVIL 1 Year			8. Date of Bir (Month, Da Aug • 5	M	ONTO	9. Birthp		or Foreign
				nerv		ity, Town or Lo		ng							Od. Inside	
5-UU36 72 hours after death with the Maryland natural; or Items 23s or 28s-1 show	nust be notified	a Diec	10e. Street and Number 112 Old Bonifant	Road			10f. Zip	Code 0905		2 (2-		Un	ited	Sta	tes	
U35 ours after de: ral', or Item	Examinarin	Dy ru	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces: 1 Yes 2 If Yes, Give X Year or Dates:	No	1	Was Deced If Yes, spec			gin? (Spe n, Puerto	ecify Yes or No Rican, etc.)		Black Specify:	, White,	white	<u> </u>
21215-U d within 72 ho piene. r than "natu	the Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 12	ducation ade completed) College (1-4or	5+)		kind of wo DO NOT u	rk done d se retired	luring mos		_{ng} inator		allu			ersity
be filed that Hyg		o pe C	17. Father's Name (First, Middle, Las Robert Spinks 19a, Informant's Name/Relationship			19h Maili	na Address	(Street	Bess	sie S	First, Middle Spinks J Route Numb				Code	
	or other traumatic		Holly Jo Barthol 20a. Method of Disposition XXBurial 2 □ Cremation 3 6	Low, Daugh	20b.	112 Place of Dispo cemetery, cree	Old E	Bonif ne of other place	ant I	Road,	, Silve	r Sp	ring	, MD City or To	2090 wn, Stete	15
arte orte	any injury once.		*4 Donation 5 Other (Special Service Lice	-	la Pa	arklawn					al Hom ing, MD		ckvi 1800 04			shire
Physic			23a. Pertf. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a RESP	IRA	ath. Do not en	ter the mod	le of dyin	g, such as	cardiac c	or respiratory a	rrest,			Approximation on the Approximation of the Approxima	ate etween
BOX 68760, eath certificate be executed attending physician and	ue burial-transit	cal Exa	Sequentially list conditions, if any teaching to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	a conse	CAN C	Erz	V-88							120	Dity
Of VITAL HECORDS, P.O. BOX 08 Physician: The law requires that the death certifical this certificate has been signed by the attending phy	thed for use as t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fel	tal death 3	⊒Ectopic pi ⊒ Other (sρ						23d. Date Mon		ery Day	Year
COFGS, P. W. requires that It been signed by	ould be detached	ed by Pn	Part II. Other significant conditions DEHY DRATION	contributing to death I	but not re	esulting in the u	inderlying o	ause givi	en in Part I			tobacco u Yes 2			ne cause of	f death? _Unknown
Vital Reco	r, page 2 sho	Completed by									1 Yes	psy ormed? 251No	pi di	ere auto for to co eath?	noiselan of	s available cause of
Division of Vital Records, to a Attending Physician: The law requires that deer death. Director: After this certificate has been signe	P P	lon: Io Be	25. Was case referred to medical examiner? 1 Tyes 25 No 27. Manner of Death 1 Tatural 5 Pending	Hospital: 1 X Inpate 28a. Date of Inj (Month, Da		ER/Outpatie 28b. Time of Injury		28c. Injun Worl	er: 4 □ Nu ⁄at	ırsing Ho	me 5 Resi Resi Residented Residented dence			v)		
DIVISION To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After	ed in by the i	Medical Certification:	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be an Blace of In	ijury - At tc. <i>(Spec</i>	home, farm, st			163 20	_	28f. Location (City or To			r or Rura	l Route Nu	ımber,
the Hospil in 24 hour the Funer	pletely fill	ledicai	(Check only 2 Medicel Exe	Physician: To the bes eminer: On the basis and manner s	of examir		vestigation	i, in my o	pinion, dea			date and	f place, a	nd due to	the cause	
To To I	ПОО	2	29b. Signature and title of certifier 30. Name and address of person who	C m >	death (Ita	em 23a) (Type	D	317				JAN	Vinzy	09		004
Re	Stat		HERBERT M. 31. Date filed (Month, Day, Year)	JV ARBE 32. Regist	1924 trans/Sign	em 23a) (Type, MUNGUM nature	1ERY V	l'LLAT	E AV	E. F-2	3 MONT	7,0146	EM VI	LLAG	E MD	2888

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene -State Registra-AMEND ITEM #1 PER PHY G827 1/20/04 Dertificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** J. BARNHARDT 4:25 P.M DOROTHY Barnhardt January 13 2004 Dorothy M /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Catonsville Baltimore 220 Radstock RD 8. Date of Birth (Month, Day, Year) 02/24/1927 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months Hours 1 □ M 2 1 F Director Indiana 309-24-7770 76 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🗙 No Directo Catonsville <u>Baltimore</u> 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Items 23a 220 Radstock RD 21228 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 6 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 Widowed 4 Divorced "natural" White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry i Hygiene. Elementary/Secondary (0-12) Cottege (1-4or 5+) 12 Homemaker Own Home permit. Pages 1 and 2 should be filed: Department of Health and Mentat Hygie Important: if Item 27 Is marked other! any Injury or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Julius Miklosy Jenny Matlasovoc 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hugh Barnhardt/Husband 220 Radstock RD Baltimore, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 □Donation 5 □ Other (Specify) 01/18/2004 Balto-Wash Crematory Laurel, MD 21. Signature of Funeret Service Licensee Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Ave, Baltimore, MD 21228 WENT 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock or heart failure. List only one cause on each line. and Death Immediate Cause (Finat disease or condition resulting in death) Physician 21/2 week ASUBU /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of) use as the burialphysician P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ 4 Unknown 1 Yes 2 No 3 Probably Completed 24a. Was an autopsy performed? 1 ☐ Yes 2. No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Naturat 2 ☐ Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funeral Diractor: , completely filled in by the f 6 Could not be determined 3 ☐ Suicide Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitel Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signaure an tille of certifier 29c. License number 29d. Date signed (Month, Day, Year) Take 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DARDORG Stick A 1130 N. Rolling 13 TAYONSVIlle, 1120 N. Kolling 16d. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 1 5 2004 Registrar

			5	State of Man	/land / Depa			•	ene	
			1 - State Registrar		•	tificate of L			g. No. 2001	00712
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	/Media	al	Leonard J. Batem			4b. City, Town, or	Location of Door	01	14 04 4c. County of Dea	6:00 P M
	Examin	er	6757 Ransome Driv			Baltimor		u i	N/A	a(r)
	Funeral		5. Social Security Number 6. Sex	7. Age (li	n yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		9. Bi	thplace (State or Foreign
h	Director			M 2□F 67	Yrs.	World Days	Notes News	10- 01-		Tand
	land		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits
	Mary 1-1 sh	tor	MD N/A		Baltimor	е				TXXYes 2 □ No
	ith the	Director	10e. Street and Number	•		10f. Zip Code		10	g. Citizen of What C	ountry?
	s 23s		6757 Ransome Dri			21207			U.S.	
	ther de	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Eve Armed Forces? 1 □ Yes 2 ☑ No	rin U.S. 13. 1	Was Decedent of Hi f Yes, specify Cuba	n, Mexican, Puer	to Rican, etc.)	14. Race - Am Black, Wh	
93	raf', o	þ	3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		1□Yes 21√2 No	Specify:		Specify: Ţ	√hite
5-0	within 72 hours atter death with the Maryland ene. than "natural", or items 23s or 28s-f show its Madical Examiner must be notified at	Completed	15. Decedent's Edu (Specify only highest grade		16a. Deced	dent's Usual Occupa kind of work done o DO NOT use retired,	ation furing most of wo	rking 1	6b. Kind of Business	s/Industry
121	within ene. than	дшс	Elementary/Secondary (0-12)	College (1-4or 5+)		ness Owne			Business (Owner
2	be filed within 72 hours after death with the Marylan ital Hygiene. ed other than "natural; or flems 23s or 28s-1 show event, the Medical Examiner must be notified at	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nar	me (First, Middle, M	laiden Sumame)	
<u>Ja</u>	2 should be and Mental is marked c	To E	Leonard J. Bate	man Sr.			Mary l	Helen Bre	mmer	
Jan	s 1 and 2 should if Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Ty)	oe, Print)					City or Town, State,	
9	Health Health tem 27 other tr		Susan Bateman 20a. Method of Disposition		20b. Place of Dispo	sition (Name of			Md. 21207	
ב פ	Pages nent of unt: If it		1 ☐ Burial 2 ☑ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	•	natory`or other place -Washine t			Laurel, M	
Baltimore, Maryland 21215-0036	permit. Pages Department of Important: If II any injury or c		21. Signature of Furthral Service License			. Name and Addres				al Directors
<u> </u>	88 58		23a. Part1. Enter the disease, or compli	100			ty Road	, Randall	stown,Md.	21133-4784
	Physician /Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	элвэциенсэ об).	T 136	AIN	TUMÓR		Onset and Death MoruTH
Box 68760	ath certifica ittending ph or use as t	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim	regnancy Fetal death 3	Ectopic pregnancy			23d. Date of de Month	livery Day Year
J.	that the de ned by the a detached f	hys	9 Unknown	9∐ Unknown						
	w requires th been signed should be de	by	Part II. Other significant conditions con	tributing to death but n	ot resulting in the ur	nderlying cause give	n in Part I.			o the cause of death? robably 4 DUnknown
II Records,	The larate has	Completed						24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of 2 \(\text{No} \)
Vital	Physician: this certificatal director, pro-	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	• C 60/0 · ·	Othe	· ·	ath Check only ne		
on of	ng Phy fter this ineral d	-	27. Mann r of Death 1 ratural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	2 ER/Outpatien 28b. Time of Injury	28c. Injury Work	at Nursing H	28d. Describe how	ce 6 Other (Spe v injury occurred	icify)
Division	al or Attanding s after death. I Director: After d in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (S	At home, farm, stre Specify)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
	To the Hospital or Att within 24 hours after de To the Funeral Direct completely filled in by t	Medical C	29a. Certifier 1 Certifying Physical Control (Check only one) 2 Medical Examination	sician: To the best of m ner: On the basis of exa and manner stated	amination and/or inv	occurred at the time restigation, in my op	e, date and place inion, death occu	, and due to the cat irred at the time, dat	use(s) and manner as e and place, and due	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		1	29c. License	number ///	29	d. Date signed (Mont	h, Day, Year)
	A		30. Name and address of person who co	mpleted cause of death	(Item 232) (Type, I	Print)	11 (311	1 1	1/// ()	1001
	∫() Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	Signature 6	2101K	Ht /	me, 121	ra, MO	21215.
41	Registr		JAN 1 5 2004	Mas .	A. 6300					

		ľ	For State Registrar	State of	f Marylan		artment of I		nd Mental Hy	giene 2 (004	00713
	Physici /Medio		Decedent's Name (First, Middle Mary	, Last)		Bur	ke		2. Date of De Month Januar	Day	Year 2004	3. Time of Death 1:40 A M
	Examin		4a. Facility Name (If not institution Mariner Health	of Glen B	urnie		4b. City, Town, Glen Bu	rnie			Arun	
	Funeral Director		5. Social Security Number 218-07-9516 Usual Residence of Decedent	6. Sex 1□ M 2√2 F	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 2 Hours	Min. 8. Date of Bit (Month, Pa	th ay, Year) 7, 1915	9. Birthpl Count MD	lace (State or Foreign try)
	the Maryland 28a-f show	Director	10a. State 10b. County	Arundel		y, Town or Lo Glen I	Surnie			10g. Citizen of \		0d. Inside City Limits 1 ☐ Yes 2 ▼No
9	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or iteme 23a or 28a-1 show aumatic event, the Medical Exacutar trust be rightled at	Funeral	1017 Cayer Dr 11. Marital Status 1 Never Married 2 Marr	12. Was Dece Amed For	2 No		2106	Hispanic Orig an, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)	U.S.	A. ce - America ck, White, e	an Indian,
Maryland 21215-0036	vithin 72 hours ne. han "natural", e Medical Exa	Completed by	3 Widowed 4 Divorced 15. Deceden (Specify only highes Elementary/Secondary (0-12)	Year or Da	ates:	16a. Deced (Give life. L	dent's Usual Occu kind of work done DO NOT use retire	pation during most	of working	Specify 16b. Kind of Br	will.	
land 2	ould be filed within 72 Mental Hygiene. arked other than "nat atic event, ILe Medici	To Be Co	17. Father's Name (First, Middle, Charles D.			Sales	3		's Name <i>(First, Middle</i> cesa DiVeni			
re, Mar	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 Is marked any injury or other traumatic ev		19a. Informant's Name/Relations Mr. Robert E. Br 20a. Method of Disposition	urke / sor	20b. P	2310 lace of Dispo	-	nes Dr.	or Aural Aoute Numb , Unit #21 Date		o, FL	33771
Baltimore,	permit. Page Department o Importent: If any injury or ance.		1 ☐ Burial 2 ☒Cremation 4 ☐ Donation 5 ☐ Other (S	pecify)	State	esapeak	ce Cremat	ion Ja	an 13,2004 Singleton	Funera1	Home	P.A.
	Physician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on e	aused the death ach line.	Dem			S.W., G1er ardiac or respiratory a			Approximate Interval Between Onset and Death 2 42005
30,	Examiner sician and purial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	or as a consequ	Empl	phasia n Sema					3 months.
O. Box 68760	ath certificate ittending phy or use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{B} \text{No} \) 9 \(\text{Unknown} \)	1 Live bi	come of pregna irth 2 Fetal ant at time of de own	death 3	Ectopic pregnanc	y		23d. Dai Mo	te of deliver	ry Day Year
ords, P.	w requires that the de been signed by the a should be detached t	by	Part II. Other significant condition	ons contributing to de	eath but not resu	ulting in the ur	nderlying cause gn	ven in Part I.				e cause of death?
tal Reco		Completed	25. Was case referred to medical					00 8:	1 ☐ Yes	rmed? c 2⊠No 1	Were autoportor to comdeath?	sy findings available apletion of cause of
Division of Vital Records,	Phys this aldi	tlon; To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	Hospital: 1 🔲 le	npatient 2 🗆 i	ER/Outpatien 28b. Time of Injury	28c. Inju	ner: 4 🗷 Nurs		200		
Divisi	To the Hospital or Attending i within 24 hours after death. To the Funeral Director: Atter completely filled in by the funer	Certification;	3 Suicide 6 Could determ		of Injury - At ho	ome, farm, stre	eet, factory, office			Street and Numb wn, State)	er or Aural	Route Number,
	the Hospil nin 24 hour the Funera	Medical	(Check only 2 Medical one)	Examiner: On the ba and mann	asis of examinat	wledge, death tion and/or inv	vestigation, in my o	pinion, death	place, and due to the coccurred at the time,	date and place,	and due to	the cause(s)
)	To with	-	29b. Signature and title of certifie		Mp.	· t		405			104.	
	4		30. Name and address of person MIRTA M NUS 31. Date filed (Month, Day, Year)	AIREE, 7	e of death (Item % 45 () egistrar's Signa	AKWOCK	Print) PROF BL	dg, Gl	en Burn	e, 2106	1,	
100	Sta Registr		JAN 1 5 2		ARA A	Ane	de)					

		•	For State Registrar	State of Ma	ryland /		tment of H			giene 20 (00714
			Decedent's Name (First, Middle, Last)						2. Date of Dea	ath	3. Time of Death
	Physicia /Medic		Rosemary	Dolores	Boh	le			Month	Day 13 2	Oay 16,24 PM
	Examin		4a. Facility Name (If not institution, give s	()	0.4.4		2	or Location of Death	1,	4c. County of	Deeth
			Jivai Hospital		thmo	re	-	use li	ty		ore City
	Funeral		5. Social Security Number [®] 6. Sex 218-26-4599	7. Age	e (In yrs. last 72	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min,	8. Date of Birt (Month, Da	y, Year)	Birthplace (State or Foreign Country)
	Director	, }	Usual Residence of Decedent	21	12				10-26-1	.931	MD
	yland		10a. State 10b. County		10c. City, To	own or Loca	ition				10d. Inside City Limits
3	Mar B-f at	to	MD Anne Arund	.el	Broo	klyn					1 ☐ Yes 2 XNo
4	ith the Marylan or 28a-f ahow or notified at	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of Wha	at Country?
8	death with the Maryland rms 23a or 28a-f ahow froust be notified at		5304 4th Street					21225			SA
1	ar dea	Funerai	T. Maria Gialas	Was Decedent E Armed Forces?		13. W	as Decedent of F res, specify Cub	tispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Black,	American Indian, White, etc.
36	rs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 [X] N If Yes, Give Year or Dates:	10	1(∃Yes 2⊠No	Specify:		Specity:	white
Rosemany 21215-0036	72 hours after natural', or Its orgal Exercities		15. Decedent's Educ	ation	11	6a. Decede	nt's Usual Occup	pation		16b. Kind of Busin	ness/Industry
27c 215	within 7. ene. than "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5	+)	life. Do	nd of work done O NOT use retire	during most of word)	King		
212	filed wil Hygien other th	Con	12				Bookkee	T*-		Real Est	tate
\ Ind	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)							Maiden Sumame)	
yla	should nd Men marke umatic	٦	Frank Bohle	m ·		101 11 11			ry Ann M		7.0.11
en as	is 1 and 2 should be filed withir of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, II a M.	1	19a. Informant's Name/Relationship (Typ. Mr. Cyril Bohle / b	,				Dr., Glen		er, City or Town, Sta • MD 210	
3 .	1 and Healt em 2		20a. Method of Disposition	Tother		the second second	tion (Name of atory or other pla	and the same of th	Date	20c. Location - Cit	
72 00	Pages ent of nt: If it ry or o		1 XBurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Denation 5 ☐ Other (Specify)	emoval from State	1	_{etery, crema} Haver		^(ce) 1/17	/2004	Glen Bur	
Baltimore			21. Sign ture of Funeral Lervice Ligense	θ	oren					Funeral I	
ahim Balt	permit. Departri Importa any inju		My me syllas	MO:	1365	1	Second A	Ave SW, G	len Burn	runerar i	1061
Por			23a. Part1. Enter the disease, or complik shock, or heart failure. List only on	ations that caused	the death. D						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	0 04430 017 0441 111	Len (1'0					Onset and Death
	/Medical		resulting in death)	Due to (or as	a consequen	ce of):		0.1			
1	Examiner		Sequentially list conditions.	Due to (or as a Due to (or a) Du	hi or	san	Syste	n face	lune		2 weeks
	pe tis	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequen	ρ 6 of): Λ	1 7	٧			1-
OX.	executed in and ial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a	a consequen	ce of):	replu	condi			Succes
8760	bur	dical E									
9	ficate g physics the	40								*	
Вох	leath certific attending pl	lan/M	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome : 1 □ Live birth			ctopic pregnanc			23d. Date of	of delivery
	that the death ed by the atte detached for	sicia	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant at			Other (specify) _	y 		Month	Day Year
P. O.	at the	Physic	9 🗌 Unknown		-						
s,	Physicien: The law requires that the death certificate has been signed by the attending pratificate has been signed by the attending pratificator, page 2 should be detached for use as	by	Part II. Other significant conditions con	1.	44	g in the und	erlying cause giv	ven in Part I.			ite to the cause of death?
ord	requi	Completed	Cormany W.	ery ou.	tease				-		
၁ခု	e law has b	npie							24a. Was autop perfor	an 24b. Wei	re autopsy findings available r to completion of cause of th?
a F	icien: Th certificate rector, pag								1 ☐ Yes	212 No 1 🗆	Yes 2 No
Zi.	Physicien: The this certificate has all director, page) Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital:	2005	(0	3□ DOA Ott	26. Place of Dea			(0 1)
Division of Vital Records, P.O.	Phys or this oral di	oz :c	27, Many er of Death	28a. Date of Injur (Month, Day		Outpatient b. Time of	28c. injui	ry at		lence 6 Other (Ѕреспу)
ion	Attsnding r death. ector: After	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	(Year)	Injury	Wo M 1□	rk?]Yes 2 □No			
Vis	Atts ar dea ectol by th	ifica	3 Suicide 6 Could not be determined	28e. Place of Inju-	ry - At home	, farm, stree	et, factory, office		28f. Location (S City or Tow	Street and Number (or Rural Route Number,
Ō	tel or rs afte el Diu	Certification;		Dundary, oto	(0,200)					, 5.6.107	
	To the Hospitel or Attanding I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	29a. Certifier 1 Certifying Physical Check only one)	ician: To the best of er: On the basis of and manner sta	examination	dge, death of and/or inve	occurred at the ti stigation, in my o	me, date and place opinion, death occu	, and due to the or rred at the time, o	cause(s) and manne date and place, and	er as stated. I due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	, ,	Atta		29c. Licens			29d. Date signed (A	
			Mhonde for	my m	Surgeon	^		588 22		1/13/0	7
	1.		30. Name and address of person who co								
	U		1 10 100 111001	Strai Ho	r's Signature		a iti wiev	E 21215			
	Sta Registr		31. Date filed (Month, Day, Year) JAN 1 5 2004	All LAZ	ir s signature	hans	وجع				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2001 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 0330 2004 Alice Bistles /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) Examiner 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) NIA HUNDER 14 Hrs. 8. If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Min 9 1 M 2 F 226-32-2013 April 25,1909 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than "naturel", or Itame 23a or 28a-f ehow any injury or other traumatic event, the Medical Examinating to notified at 1 Pres 2 No altimore Director MD10g. Citizen of What Country? 10e. Street and Number 2/2/7

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 29 Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Rece - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Black Baltimore, Maryland 21215-0036 Specify: If Yes, Give Year or Dates: Specify: Completed by 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private HouseKeeper 5 th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Eleanor Douglass Reed Reed 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Warne/Relationship (Type, Print) /grandclava hter ZZIZ N. Rosedale Boultmore MDZIZIL Doreen Kidd 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Jan. 13, 2004 Crownsville rownsuille VA Cem. • 4 □ Donation 5 □ Other (Specify) Foneral Service 22. Name and Address of Facility 21. Signature of Funeral Service Doenses Hari P. Clusp 1 Baltimore MD 21201 St. Approximate Interval Between 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Moningitis

Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed use as the burial-transit that inifiated events resulting in death) Last Due to (or as a consequence of): the attending physician Division of Vital Records, P.O. Box 68760 Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months?

1 Yes 2 No
9 Unknown Month 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown After this certificate has been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2 3 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury al Work? 28d. Describe how injury occurred 27. Manner of Death To the Hospital or Attending I within 24 hours after death.
To the Fundhal Director: After t Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 176 Stephanie Bohum MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mo Greene 32. Registrate Signature 31. Date filed (Month, Day, Year) State 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 1 5 Certificate of Death

Reg. No.

12. Date of Death 3.

		Í	1 - For State Registrar	,	Cei	rtificate of I	Death	Ra	g, No.	7 00/16
	4 F		1. Decedent's Name (First, Middle, La	ist)				2. Date of Death		3. Time of Death
1/21	Physicia /Medic		ANGELA L	. BARTE	E			Month	Day Zucy	4:45 PM
	Examin		4a. Facility Name (If not institution, gir	re street and number)		<u> </u>	Location of Death	-	4c. County of Dea	
		٨	JOHNS HOPKINS I	BAYVIEW CARE C	ENTER	BALTI	more		BAINMOR	or CITY
4	Funeral	,		Sex 7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bi	rthplace (State or Foreign ountry)
	Director		219-66-5227	10M 20F 49	Yrs.			October 13	1954	and
5-50	pug *	}	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	ncation			, , ,	10d. Inside City Limits
	sho	5	Mn 4)/	Λ Ω	4 1 1	1				1 ∑¥es 2 □ No
	the N	Director	10e. Street and Number) 5	alti	10f. Zip Code		10	g. Citizen of What C	
	with			0/- 0		212	17	"	USA	
	leath ns 23	Funeral	2526 E.	12. Was Decedent Ever in U.	S. 13.	Was Decedent of H		pecify Yes or No-	14. Race - Am	
10	ther of the c	ᇤ	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No		If Yes, specify Cuba	in, Mexican, Puerto	Rican, etc.)	Black, Whi	te, etc.
ဗ္ဗ	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Specify:	lack
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28a-1 show the Medical Examinar must be notified at	Completed	15. Decedent's E (Specify only highest gr		16a. Dece	dent's Usual Occup	ation	ring 1	6b. Kind of Business	/Industry
2	thin 7	ad l	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	"		~	, ,
	er th	5	975			Secur	ity OFF	ie (First, Middle, M.	10 ON	ben Securit
nd	d oth	Be	17. Father's Name (First, Middle, Las							{/
<u>کا</u>	should ind Men	မှ	Preston Pa						Bartep	
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylar it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23e or 28a-1 show or other traumatic event, the Medical Examinar must be notified.	e V	19a. Informant's Name/Relationship	// //					City or Town, State,	• •
	l and fealth im 27 har t		Celestine B.	Jennings Jawg M		13 / Ce	donia A			0051506
0	ges it of h if ite or of		20a. Methød of Disposition 1 🖾 Burial 2 ☐ Cremation 3 [¬¬ ,, a, l a	emetery, crei	natory or other place	θ)	,	Oc. Location - City or	
ţ	Part Part		`4 □Donation 5 □ Other (Special	(y) J	rbute	15 Mem 1	ok 1/17	704	Arbutu	I, MD
Baltimore,	permit. Page Department o Important: If any injury or once.		21. Signature of Fune at Service Lice	nee-	22	Hame and Address	close 1	Funera	Service	e, PA
	40240		22a Bort Enter the disease or on	aplications that arread the death		10976	SSIENC S	1. 139	et. , rue C	Approximate
	8. E.		23a. Part1. Enter the disease, or con shock, or heart failure. List only	one cause on each line.		er the mode or dyin	g, such as cardiac	or respiratory arres	51,	Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. ARRHY THI	MIA					MINUTES
	/Medical Examiner		1	· ·						0.0145
B		_	Seventially list conditions, if any, leading to immediate	b. UROSEPSI						DAYS
	ted nsit	를	cause. Enter Underlying Cause (Disease or injury	(
_	ortificate be executed ing physician and e as the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequ	uence of):					
60	be e									
68760,	ficate physis the	Medical		0						
Вох	eath certificate be executed attending physician and for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d. Date of de	livery
	death e atter ed for u	cla	in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		∃Ectopic pregnancy ∃ Other (s <i>pecify</i>)			Month	Day Year
o.	w requires that the death or been signed by the attend should be detached for us.	Physiclan/	9 Unknown	9□ Unknown						
s, P	s tha		Part II. Other significant conditions	A A		2		23e. Did toba	icco use contribute t	o the cause of death?
ğ	quire on sig uld b	be	CARSIUMYOPATHY	, ANEMIA, AN	loyc E	BRAIN IN	riky,	1 🗆 Yes	: 2□No 3127Þ	robably 4 Unknown
Division of Vital Record	The law requires that the ate has been signed by the bage 2 should be detache	ompleted by	CHRONIC RENA				_	24a. Was an	24b. Were a	utopsy findings available
æ	The lav	E			/			autopsy	ed? death?	completion of cause of
ital		C	25. Was case referred to medical				26. Place of Deal	1 Yes 2		2 140
\leq	8 s 5	To B	examiner? 1 □ Yes 2 ☑ No	Hospital:	ER/Outpatier	nt 3 DOA Othe	or:		ce 6 □Other (Spe	ocify)
0	ig Phys ter this neral di		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time or	f 28c. Injun Worl	/ at	28d. Describe how		
<u>0</u>	Attending It death. Sctor: After by the fune	ertification:	2 ☐ Accident investigation	on	July		Yes 2□No			
Nis	r Atte er de recto by th	tific	3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined		me, farm, str	eet, factory, office		28f. Location (Stree City or Town,	et and Number or R State)	ural Route Number,
	ital or A	O								
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	edical	29a. Certifier 1 ☐ Certifying P (Check only 2 ☐ Medical Exa	hysician: To the best of my kno- miner: On the basis of examinat	wledge, death	h occurred at the tim	ne, date and place,	and due to the cau	ise(s) and manner a	s stated.
7	To the houthin 24	Medi	one)	and manner stated.						· ·
	Mit o	<	29b. Signature and title of certifier	200		29c. License	リワルー	7	d. Date signed (Moni	
7	17		My	A MC			1-0/	30	envery 1,	2004
			30. Name and address of person with	dompleted cause of death (Item 0006H 5505 H	23a) (Type,	Print) S BALLUS I	N Pipale	BA Dun	RE MI	21274

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

JAN 1 5 2004 Meens & Griginal

			1 - For Stata Registrar	State of Marylar		rtment of F			ene 2004	00717
	Physici	an	1. Decedent's Name (First, Middle, Last)	1	01	0111	- 1	2. Date of Death Month	Day Year	3. Time of Death
	/Media	cal	4a. Facility Name (If not institution, give s		KAD	S HA	r Location of Dea	JANUARY	4c. County of Death	1:30 p M
	Examir	ier	4719 RUBY AV			HAL	ETHO	RIE	BALTI	nors
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	_	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	(Month, Day,	(ear) 9. Birth	place (State or Foreign ntry)
	Director		2 3 - 09 - 9385 12 Usual Residence of Decedent	89	Yrs.			FEBRUARY 1		ARY LAND
	ryland thow		10a. State 10b. County		ty, Town or Loc	ation				10d. Inside City Limits
	8a-f	Director		1 MORE 1	TALE	THOK	PE			1 ☐ Yes 2 ☑ No
	with the part of t	Dir	10e. Street and Number 4719 RUSY	AUE		10f. Zip Code	211.7	109	g. Citizen of What Cou	ntry?
	death	Funeral		12. Was Decedent Ever in U	.S. 13. W	as Decedent of H	lispanic Origin? (Specify Yes or No- nto Rican, etc.)	14. Race - Ameri	
36	s after or Ita		1 Never Married 2 Married	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give	١,	Yes, specify Cuba		no Hican, etc.)	Black, White,	
2-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygens. is marked other than "natural", or Itams 23a or 28a-f show aumatic event, It a Medical Exactinatinatic event, It a Medical Exactination	ed by	3 Widowed 4 Divorced	Year or Dates: 1990		ent's Usual Occup	ation	16	Specify: Uh	
215	thin 72 e. en "na Medic	Completed	(Specify only highest grade Elementary/Secondary (0-12)		(Give k	ind of work done of NOT use retired	during most of we	orking	_	Sustry
2	led wil lygien her th			2 years	Adr	1 (N(STIA			GOVERNME	<u>t</u>
Maryland	be d at a	o Be	17. Father's Name (First, Middle, Last) John Crock	1-44				me (First, Middle, Ma	,	
ary	d 2 should th and Mer 7 is marke traumatic	은	19a. Informant's Name/Relationship (Ty)		19b. Mailing	Address (Street		TLE PE Jural Route Number, (City or Town, State, Zip	Code)
	D € ► ₽		ELIZABETH JONE	ES (DAVOITION)	P. O. B	ox 237,	Underhi	11 Center, 1	lernort 054	90
Baltimore,	Pages 1 an nent of Heal int: If Item 2 iry or other		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R	emoval from State	Place of Dispos cemetery, crem	ition (Name of atory or other place Arund et TOLY	ce)		oc. Location - City or To	
E T			* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License		REMA	TORY Name and Address	SAN)	My 15, 2004 6	devitor n	10
Ba	permit. Departr Importe any inje		Juanto RJ	Dames	A	extone	Griffe 6	Portsky 75	H Convel (Do ma 21076
			23a. Part Enter the disease, or complishock or heart failure. List only on	cations that caused the deat	h. Do not ente	r the mode of dyin	g, such as cardia	c or respiratory arres	1.	Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	CONGES	TIVE	HEAT	LT F.	AILURE		Onset and Death
-	/Medical Examiner			Due to (or as a conseq		~ ~ ~ .		-1		
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq		moio M	LYCIPAI	117		
	ecuted and transi	Examin	Cause (Disease or injury that initiated events resulting in death) Last							
8760,	cate be executed physician and the burial-transit		rosuling in dodiny cast	Due to (or as a conseq	uence of):					
	cate phy:	edical	d							
Rox	that the death certifi ed by the attending detached for use as	Physician/Me	23b. Was decedent pregnant	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta		Ectopic pregnancy			23d. Date of delive	-
	the dea y the at sched fo	ysici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of d 9☐ Unknown		Other (specify)			Month	Day Year
<u> </u>	that the		Part II. Other significant conditions con	tributing to death but not res	ulting in the und	derlying cause give	en in Part I.	23e. Did tobar	co use contribute to the	ne cause of death?
Records,	The law requires that tte has been signed b oage 2 should be deta	ed by	ATMAL	FIRML	ADUL	ე.		1 ☐ Yes	2□No 3□Prob	ably 4 Unknown
မင္	law re as ber 2 sho	Completed						24a. Was an autopsy	24b. Were auto	psy findings available
						_		performe	d? death?	·
Vital		o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3□ DOA Othe	20	ath Check only ne	0 Floring (0-1-1)	
	ig Phya ter this neral di	H .	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe how	e 6 □Other (Specify injury occurred	//
<u> </u>	Attending r death. ector: After by the fune	catic	1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			M 10	Yes 2 □No			
	al or At after of Direct d in by	Certification;	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stree y)	et, factory, office		28f. Location (Stree City or Town, S	et a <i>nd Number or Rur</i> a State)	l Route Number,
/	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical (29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, death tion and/or inve	occurred at the timestigation, in my op	ne, date and place pinion, death occu	e, and due to the causurred at the time, date	se(s) and manner as st and place, and due to	ated. the cause(s)
	To the To the comp	Me	29b. Signature and title of certifier	15		29c. License	number 5 4/	Q 29d	Date signed (Month,	Day, Year)
-		-		/		1)4	クメイ	7	11/7/04.	
	10		30. Name and address of person who con	mpleted cause of death fitch	1 23a) (Type, P	#102	2 Gle	n Bu	rnie 1	D 2106
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar Signa 5 200	ture J.	books	,			•

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Eleanor I. Chitty 1.3 Р January 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Crofton Convalescent Center Crofton Anne Arundel 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) MAR 19, 19 Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☒ F Director 510-01-9910 85 1918 Kansas Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits in than "natural", or items 23a or 28a-f show the Medical Examplement be netitied at 1 ☐ Yes 2 ☑ No Maryland Anne Arundel Crofton Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1926 Cambridge Drive 21114 USA death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be fited within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: White 3 □Vidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygienn Important: If item 27 is marked other the any injury or other traumatic svent. Lagant. Secretary of Defense 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Louis A. Schlesener 2 Paulena Koepke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda B. Chitty/Daughter 1926 Cambride Drive Crofton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location · City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Metro Crematory Inc. 1-14-04 Baltimore, MD 21. Signature of Funcial Service Lines ee ^{22. Name and Address of Facility} Cremation Society of MD. 299 Frederick Road Bal inc. Edward AJ Gregorchik 21228 Baltimore. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician spination resulting in death) /Medical ue to (or a consequence of): Examiner S uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): The law requires that the death certificate be executed Exam 0 and resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has linector, page 2 s autopsy performed? Yes 2 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No ₽ 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) CULOU January 14, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 222 14300 Gallant Fox Lane, Bowie, MD 32, Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 8 35 **Physician** Doroth 4.SSAD 2004 Tanua, <u>/2</u> /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e. Fecility Name (If not institution, give street and number) Examiner University of Maryland N/A Systems Baltimore Medical If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs! last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 257F Yrs. Director 215-22-5633 DEC 8. 1927 76 Maryland Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Exercises must be notified at N/A 1 Yes 2 □ No Maryland Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21223 1547 Cole Street USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1□Yes 2XINo Specify: Specify: δ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "na any injury or other traumatic event, tra Media 90ce. Elementary/Secondary (0-12) College (1-4or 5+) Stock Puller Customer Service 9 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John C. Goss, Sr. Jessie Fitzgerald 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrew Cassup, Jr./Husband 1547 Cole Street Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 1-17-04 Baltimore, MD 21. Signature of Funered Service Licensee

Homos Gregori MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician obstructive disease or condition resulting in death) MONIC Dulmonary /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or intury Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) be detached 2 No the 9☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by rena Yes 2 No 3 Probably 4 Unknown page 2 should peen : 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 Inpatient 3 DOA P 2 ER/Outpatient within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. the 29b. Signature and time of certifie 29c. License number 29d. Date signed (Month, Day, Year) P1649 1.0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10. 2120 Smith Baltimore, Maryland Matthew S-Green 31. Date filed (Month, Day, Year) Registrar Signature State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item#10cperFHG827 1/15/04 EW Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2004 Month Physician 2395 Curry D. Wynwood 4b. City, Town, or Location of Death /Medical 4a Facility Name (If not institution, give street and number) 4c County of Death Examiner Laure Regional If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. Months **N** M 2 □ F Director 217-80-0304 12-25-61 Md. Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at 1√D Yes 2 □ No Directo Baltimore Laurel Prince George's 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Apt. 3914 13028 Old Stagecouch Rd. 20708 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Item any Injury or other traumatic event, the Medical Examina 1 Yes 27 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Black þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer Varies 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Curry Wynwood Evelyn Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13028 Old Stagecouch Rd. Apt. Evelyn Curry Mother 3914, Laurel, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) King Mem. Pk. 1-16-04 Randallstown, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 March F.H. East 1101 E. North Ave 23a. Part1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of). Examiner ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medical Due to (or as a consequence of) resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 24 NO certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 2- ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined To the Hospital or Atter within 24 hours after de: To the Funeral Director completely filled in by th 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2004 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Has 3001

Registrar DHMH 16 Rev 6/95

State

31. Date filed (Month, Day, Year)

32. Registrar

			1 - For State Ragistrar	State of M		_		t of H	lealth a	and M	•		2004	00721
	Physici	an	1. Decedent's Name (First, Middle, Last) John Matthew Cefa								2. Date of De Month	aath Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give		-1		4h Cih	Town or	Location of		January	10	2004 ounty of Deat	1210 AM
	Examin	er	Sinai Hospital of	7 /1:			-	4 4 2	iore	Di Deatri		40. 00	ounty of Deat	л
a	Funeral		5. Social Security Number 6. Sex	x 7. A	ge (In yrs.	last birthday)	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bit	rth	9. Birt	hplace (State or Foreign
a a	Director		220 00 0393]M 2□F 4	46	Yrs.	Months	Days	Hours	MID.	8. Date of Bit (Month, Di Feb. 12	195	7 Mai	ryland
	and ow		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23a or 28e-f show ery injury or other traumatic event, the Medical Examinational be notified at ONG.	tor	Maryland Baltimore	e	M	iiddle i	River							1 ☐ Yes 2√∑ No
	or 28a	Irec	10e. Street and Number				10f. Zip	Code				10g. Citize	n of What Co	untry?
	23a o	al D	107 Covered Wagon	.Rd.				212	20			Ţ	JSA	
	teme 23	Funeral Director		12. Was Decedent Armed Forces	?	J.S. 13.	Was Deced	ent of Hi	spanic Ori	gin? (Spe n, Puerto f	cify Yes or No Rican, etc.))- 14.	Race - Ame Black, White	
36	rs after r, or ite	by Fi	1 Never Married 2 Married 3 Widowed 4 XDivorced	1 X Yes 2 ☐ If Yes, Give Year or Dates:			1□Yes 2)	pecify: Wh	
- 9	tural	edt	15. Decedent's Edu			16a. Dece	dent's Usua	I Occupa	ation			16h Kind	of Business/	Industry
215	within 72 ene. than *na	Completed	(Specify only highest grade Elementary/Secondary (0-12)	e completed) College (1-4or	5+1	(Give life.	kind of wor DO NOT us	k done d e retired,	lu <i>ring</i> mosi)	t of workir	ng	TOD. Paris	OI DUSTINGS AT	industry .
213	ygiene gertha	Con	12			Pa	inter					Pa	ainting	3
Pul	be fill d oth	To Be	17. Father's Name (First, Middle, Last)								(First, Middle		,	
D &	should ind Men i marke umatic	၉	John Lee Ramey								Mary H			
Z Z	d 2 st th and 7 Is n traun		19a. Informant's Name/Relationship (Ty) Carolyn C. Nocella		١						Route Numb			
, S	Heal Heal tem 2		20a. Method of Disposition	(COUSTII)		Place of Dispo					lver S		tion - City or 1	
le falon	ages ent of nt: If II		1 ☑Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)			cemetery, cren k Lawn				3/20	04		more,	
Octobry, Jahn M Baltimore, Maryland 21215-0036	mit. F partme portar y injur	ı	21. Signature of Juneral Service License	-	0			_	- 1		- 1			
ä	Depa Impo		Vokn W. K.	wknex	ske	_]	Bruzdi 1407 (zins. Old	ki Fu Faste	nera rn A	l Home venue l	P.A. Essex.	Md. 2	21221
			23a. Part 1. Enter the disease, or compli- shock, or heart failure. List only or	ications that cause ne cause on each !	d the deat	th. Do not ent	er the mode	of dying	, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Acute.		cioblas	tic L	en	Kem	la				Onset and Death
	/Medical Examiner	,	resulting in death)	Due to (or as										
	, R	1	S quentially list conditions,	Due to (or as	s a consec	mence of).	-							
	uted I Insit	Examiner	S quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	500 10 (01 03	ra conseq	dence on.								
6	ite be executed ysicien and ne burial-transit	Еха	that initiated events c. resulting in death) Last Due to (or as a consequence of):											
20/	et sys	cai		J										
89)	Physicien: The law requires that the death certificat this certificate has been signed by the attending phyral director, page 2 should be detached for use as the	Med	IF FEMALE:											
Вох	attendin for use	Physician/Med	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1☐Live birth	2 Feta	ildeath 3 [Ectopic pre					23d	f. Date of delivers. Month	very Day Year
P.O.	uires that the dei n signed by the a ld be detached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	it time of d	leath 5	Other (spe	ecify)					WOTE:	Day roal
مَ	that the by detact		Part II. Other significant conditions con	ntributing to death t	out not res	ulting in the ur	nderlying ca	use give	n in Part I.		23e. Did to	obacco use	contribute to	the cause of death?
Division of Vital Records,	uires n sign lid be	۵				_	, ,				10	V/		bably 4 Unknown
Ö	s been s	Completed									24a. Was	an 2	4b. Were aut	opsy findings available
Re	The lay	ошо									aulor	rmed?	prior to co death?	ompletion of cause of
ital	ysicien: The lis certificate he director, page	BeC	25. Was case referred to medical						26. Place	of Death	1 ☐ Yes	2/ \(\D \)No	1 🗆 Yes	2 No
Ž	hysic his ca I direc	10	examiner? 1 ☐ Yes 2 No H	lospital: 1 XI npatie	ent 2	ER/Outpatien	t 3 DO	Othe			e 5 ☐ Resid		Other (Speci	ify)
e e	ing Pl	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ıry ıy Year)	28b. Time of Injury	28	lc. Injury Work	at	-	8d. Describe			
sio	Attending r death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be				М		'es 2 □ N					
ΣįΣ	I or Attendi after death. Director: A 3 in by the fu	Certification:	4 Homicide determined	28e. Place of Inj building, et	iury - At ho ic. (Specif	ome, farm, stre y)	eet, factory,	office		2	8f. Location (S City or Tox	Street and N vn. State)	lumber or Rur	al Route Number,
_	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier 17 Certifying Phys	sician: To the hest	of my kno	wledne death	occurred a	t the time	e date and	d place, as	nd due to the	201120/2) 221	d	
	the Hospitel nin 24 hours the Funerel npletely filled	Medicai	(Check only 2 Medical Examination)	ner: On the basis o and manner st	or examina	tion and/or inv	estigation,	in my opi	inion, deat	h occurre	d at the time,	date and pla	ice, and due i	to the cause(s)
	Withir With To th	M	29b. Signature and title of certifier				29c.	License	number			29d. Date si	igned (Month,	Day, Year)
	1.		K. Perkun Br	moment	>		K	YES.	0	00		Tanuar	n 10,	2004
	1		30. Name and address of person who co	mpleted cause of c	death (Item	п 23а) (Туре, І	Print)			M	ALC: NEW		N. T. J. A. N.	m 1
E-1	0		Krekin Finn,	10 S rou	its i	had in	3	rer,	2401	Au.	Galvel	int As	re fleit	horse MOZICZ
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registr	ars Signa	ture A	and s							

			1 - For State Registrar	State of Maryla	•	artment rtificate			and Me		iene g. No. 2 Û	04,	00	722
			Decedent's Name (First, Middle, Last)						2	2. Date of Deat		V	3. Time	of Death
	Physici /Medic		Melvin Elizabeth	Connelly						Month January	9, 200	Year 04	6:15	5 P M
	Examin		4a. Fecility Name (If not institution, give s	street and number)		4b. City, 1	Town, or	Location of			4c. County			
			St. Elizabeth Nur	sing Home		Ba	ltim	ore]	Balti	imore	
	Funeral		5. Social Security Number 6. Sex		rs. last birthday)			If Under 2	24 Hrs. 8 Min.	B. Date of Birth (Month, Day,			nplece (State untry)	or Foreign
	Director		212-05-1734	95	Yrs.		Jayo			Vov 25,	1908		rylan	
	and w		Usual Residence of Decedent 10a, State 10b, County	10c.	City, Town or Lo	ncation							10d. Inside	City Limite
	sho	ត	Maryland Baltimo		oodstoo									s 2√∑No
	the A	ect	10e. Street and Number	10 ,,	- COCE COC	10f. Zip	Codo	· · ·		1	Og. Citizen of	What Cor		- A
	with a or	Funeral Director				101. 2.10		63		"				
	heath	era	3324 Peddicoat Co	UEC 12. Was Decedent Ever in	U.S. 13.	Was Decede	211		nin? (Speci	ify Yes or No-	United		ican Indian,	
(0	riter	Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 212 No		Il Yes, speci	rfy Cubar	n, Mexican,	, Puèrto Ri	can, etc.)		ck, White		
ဗ္ဗ	urs a	by	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	X No	Specify:			Specif	y: W]	hite	
21215-0036	within 72 hours after death with the Maryland ene. than "neturel", or Items 23e or 28e-f show the Medical Exeminer must be notified at	Completed	15. Decedent's Educ (Specify only highest grade			dent's Usual			of working		16b. Kind of B	usiness/lr	ndustry	
7	thin 8	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use	e retired))	or working	′				
7	fited wi Hygien other th	Son	12		H	Iomema)							wn Ho	me
nd	be fit d oth	Be	17. Father's Name (First, Middle, Last)							First, Middle, M		ne)		
<u>×</u>	should be and Mental marked o	2	Charles Brown							May Br				
Maryland	i 2 should be filed v n and Mental Hygie I is marked other t raumatic event, III		19a. Informant's Name/Relationship (Type Charles Connelly							Route Number,				
	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene if Health and Mental Hygiene item 23 a or 28a-1 show item 27 is marked other than "nature!", or Items 23a or 28a-1 show other traumatic event, the Medical Exembler must be notified at		20a. Method of Disposition	·	. Place of Dispo			e cou	LTC, W	oodsto				63
Baltimore,	Pages nent of P ant: If ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re		cemetery, crei	matory or off	har niace	Park 1			lkridg			ъđ
킆	permit. Page Department o Important: If sny injury or once.		Onation 5 ☐ Other (Specify) 21. Signature of Funeral Service License			2. Name and								
Ва	permit. Departm Importa any inju		21. Signature of Funeral Service License	3, 8					Huc	bard Fu				
	4		23a. Part1. Enter the disease, or complic	cations that caused the de	_				-	Baltin		laryı	.and 2 Approxima	
,8760,	Physician /Medical Examiner the privat-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence ol):	c cc	rea	, 5 Va ,	<i>SU</i> // <i>l</i>	urd	l Jea.	fe	Onset and	rears
Вох 68	ath certific ttending p tor use as	Physician/Medi	in the past 12 months?	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of	etal death 3	Ectopic pre			_	7		te ol deliv	ery Day	Year
o.	that the de led by the a detached i	ysic	1 ☐ Yes 2 MNo 9 ☐ Unknown	9☐ Unknown	30	_ Other (3)00	C"y)							
rds, P	sign sign d be	þ	Part II. Other significant conditions con	tributing to death but not r	esulting in the u	nderlying ca	use give	n in Part f.		23e. Did tob 1 ☐ Ye.	acco use cont		the cause of	
Vital Record	aw requ	Completed								24a. Was an		Were auto	opsy findings	s available
æ	The tree to ha	Eo								autopsy	ed?	death?	ompletion of	cause of
ta		63	25. Was case referred to medical					26. Place	of Death (1□Yes 2 Check on one	3	I ∐ Yes	ZIGTINO	
<u> </u>	ysici is cer direc	To B	examiner? 1 ☐ Yes 2 2 No	ospital: 1 Inpatient 2	☐ ER/Outpatier	nt 3 DOA	Othe	- 1		5 ☐ Resider		er (Snecii	(fv)	
of	g Ph er th		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	1 28	ic. Injury Work	- Tables	-	d. Describe ho			-7/	
<u>0</u>	tending Physician: The far Jeath. tor: After this certificate has the funeral director, page 2	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(MONIN, Day 1 dar)	Injury	М		: es 2 □ N	10					
Division	e Hospital or Attend 24 hours after death 9 Funeral Director: etely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of fnjury - At building, etc. (Spec	home, farm, str	eet, factory,	office		28f	Location (Str. City or Town,		er or Run	al Route Nur	mber,
	To the Hospital or Attending Physician: which 24 hours after death at a death in certific to the Funeral Director: After this certific completely filled in by the funeral director,	edicai	29a. Certifier (Check only one) 1 Certifying Phys	ician: To the best of my k ler: On the basis of examinand manner stated.	nowledge, death nation and/or in	n occurred a vestigation, i	t the time in my opi	e, date and inion, death	d place, and h occurred	d due to the ca at the time, da	use(s) and ma te and place,	inner as s and due to	stated. o the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	1	(1)	29c	License		, ,		d. Date signe			
•	A		1///		u	V	1 1 6	77	6	1	аи.,	13,	200	4
	4		30. Name and address of person who con		ет 23а) Туре,	Print) /					17.7			
			720 Maider Ch 31. Date liled (Month, Day, Year)	OIU Lare	1110	10	-							
	Sta Registr			32. Registrar's Sig	o As	food	8							

			. For	State of Ma	ryland / De	partment of	of Health an	d Mental Hygi	ene	
			1 - State Registrar		C	ertificate (of Death	Re	g. No. 2001	+ 00723
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death 1755 M
	/Media	al	Madeline Talk 4a. Fecility Name (If not institution, give	ott Cro	uthamel	4h City Toy	vn, or Location of D		y 11 201	V4
	Examir	er	240 Second Avenue	areet and number)			downe	Galli	Baltim	
	Funeral		5. Social Security Number 6. Sex		(In yrs. last birthda	y) If Under 1 Y Months D		Hrs. 8. Date of Birth (Month, Day,	Year) 9. Bi	rthplace (State or Foreign
	Director		215-09-8478 Usual Residence of Decedent]M 2 ∏ F	89 Yrs.		.,,	June 19,		ryland
	yland sow		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	e Mar	ctor	Maryland Baltimore	<u> </u>	Lansdow	ne				1 ☐ Yes 2X No
	with th	Dlre	10e. Street and Number 240 Second Avenue			10f. Zip Co	de 1227	10	g. Citizen of What C	•
	leath v	Funeral Director		12. Was Decedent E	ver in U.S.			? (Specify Yes or No-	14. Race - Am	States erican Indian.
ဖွ	or iter	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	0		Cuban, Mexican, Po No Specify:	? (Specify Yes or No- uerto Rican, etc.)	Black, Whi	ite, etc. White
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f ehow the Madical Examiner man be mailing at	Completed by	3 ¼ Widowed 4 □ Divorced	Year or Dates:						
7	n nat	plete	15. Decedent's Educ (Specify only highest grade	ompleted)	(Gir	cedent's Usual Or re kind of work d . DO NOT use re	one during most of	working	6b. Kind of Business	s/Industry
212	giene giene er tha	Com	Elementary/Secondary (0-12)	College (1-4or 5+	7)	Homem	aker		Own Ho	ome
Maryland	be file ital Hy id oth event	Be	17. Father's Name (First, Middle, Last)	_			18. Mother's	Name (First, Middle, Ma		
7	hould d Mer marke	ဥ	Walter Samuel May 19a. Informant's Name/Relationship (Ty)		19h Ma	iling Address (St	reat and Number of	Lillian Flor Rural Route Number, 6		
	nd 2 saith an 27 is i		Robin Fuchs / Daug					Vay, Arnold		
ore,	es 1 a of Hez fitem r othe	3	20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐ R	omoval from State	20b. Place of Dis	position (Name of ematory or other	of place)	Date 20	Oc. Location - City or	Town, State
Baltimore,	. Pages tment of tant: If it		`4 □Donation 5 □Other (Specify)		Bayview	Cremato	ry 1/	13/2004 Ba		
Baj	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 23s or 28s-1 show empty factoriant: If Item 23s or 28s-1 show empty high or other treumatic event, the Medical Examiner man be coulled at once.		21. Signature of Funeral Service License	1/2		4107 Wi	lkens Ave	Hubbard Fu enue, Baltin	more, Mary	e, Inc. yland 21229
			23a. Part1. Enter the disease, or comolishock, or heart failure. List only on		the death. Do not e	nter the mode of	dying, such as care	diac or respiratory arres	t,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Duata (acasa		uclive	leng	Usease		geau
	Examiner			Due 10 (01 as a	consequence of):					
	ם יו	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence ot):					
	xecute and il-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	. Due to (or as a	consequence of):					
760,	icate be executed physician and s the burial-transit	calE		· (.						
89		B	IF FEMALE:							
.O. Box	eath certifice attending ph for use as t	Physician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome o	Fetal death 3	□Ectopic pregn			23d. Date of de Month	livery Day Year
o.	that the de led by the a detached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at ti 9□ Unknown	me or death 5	Other (specif)	v)			,
ď.	The law requires that the death certifica site has been signed by the atlending phoage 2 should be detached for use as the	by Pi	Part II. Other significant conditions con	tributing to death but	not resulting in the	underlying cause	e given in Part I.	23e. Did toba	cco use contribute to	o the cause of death?
ord	w require been si should t	ted						1X Yes	2 □ No 3 □ P	robably 4 Unknown
Records,	has b	Completed						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
_		e Co	25. Was case referred to medical		····		00 Pl	performe	No 1 ☐ Yes	2 □ No
\equiv		0 8	examiner?	ospital: 1 Inpatien	t 2□ER/Outpati	ent 3 DOA	Other	Death (Check only one) g Home 5 Resident	ce 6 □Other (Sp∈	ocify)
Division of	tending Phys leath. tor: After this the funeral di	on: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time		Injury at Work?	28d. Describe how		
Sio	Attending ir death. ector: After by the fune	icatl	2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be	One Disea of John	At home form		1 ☐ Yes 2 ☐ No	396 Lanatina (Stra		
<u>≥</u>	T ite	Certification:	4 ☐ Homicide determined	building, etc.	y - At home, farm, s (Specify)	treet, ractory, on	100	City or Town,	et and Number or Ri State)	urai Houte Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ner: On the basis of e	examination and/or	investigation, in r	ny opinion, death o	ace, and due to the cau ccurred at the time, date	and place, and due	e to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier			29c. Lic	cense number	29d	. Date signed (Mont	th, Day, Year)
)	1		> Wales Milas			D2	4781		1/12/04	
	A		30. Name and address of person who co	mpleted cause of dea	ath (Item 23a) (Type	Print)	U= 11	75 4115	BACT	21220
	Sta	te	31. Date filed (Month, Day, Year)	1 5 % Repistrar	's Signature	H hos	46 176	29d	mu	21227
	Registr	_	JAN	19 5004	MARKET .	A September				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20014

State of Maryland / Department of Health and Mental Hygiene 20014

Registrer

State of Maryland / Department of Health and Mental Hygiene 20014

Registrer 00726 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year LOWE 10:37 P^M January 3, 2004 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of/Death University Hospital Baltimore City
If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Months Davs Hours 33 215-86-497 Yrs. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No DALTIMORE +EIGLAUDO 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? 21227 U.S.A NUE SSE AVE 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Never Married 2 Married ☐Yes 2 No 1 ☐ Yes 2 ☑ No Specify: WHITE Specify: If Yes, Give Year or Dates: 3 ☐ Widowed 4 Dovorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) t7. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) UiS 20b. Place of Disposition (Name of Date 20a. Method of Disposition 2 c. Location - City or Town, State cemetery, crematory 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 2003 * 4 ☐ Donation 5 Other (Specify) 21. Sign ture of Funeral Service Licensee 22. Name 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition NARCOTIC AND COCAINE INTOXICATION resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate the first underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy **Y** Yes 2 □ No 2 No 1XXYes Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: 1 ☐ Inpatient 2 ☑ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) XXYes 2 □ No 5 Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred foundvat 5 Pending investigation 1 Natural 1 ☐ Yes 2XXNo 2 Accident 1=03-04 10,11p UNKNOWN 6 XX ould not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide FOUND LYING ACROSS FENCE SCOTT&CLIFFORD STREETS BALTO,MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) hi mil O.C.M.E. January 4, 2003

The law requires that the death certificate be executed attending physician Box 68760 use ŏ detached Division of Vital Records, P.O. the ģ signed 99 peen has certificate To the Hospital or Attanding Physician: this funeral Alter death. filled in by the within 24 hours after deat To the Funeral Director:

> State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

JAN 1 5 2004

LING LI.M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

111 Penn S

111 Penn Street, Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene 2004 State Registrar AMEND ITEM 19a PER INF G827 1/20/04 Contribute of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Cody Month 12:45 AM **Physician** Camillus Tanyan /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number)

HOWARD COUNTY GENERAL 4b. City, Town, or Location of Death Examiner General Boshula co/unipea Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** Months Days 1□M 2√2F Yrs. 217-46-2143 November 3. 1912 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f ahow rat', or itema 23a or 28a-f ahov Exeminer must be nutitied at 1 Yes 2 No Maryland Howard Columbia Director 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 5510 Harvest Scene 21044 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 "natural", or 1 ☐ Yes 2 No Specify Specify White Completed by 3 Widowed 4 □ Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) ulth and Mental Hygiene. 27 la marked other than 'r traumatic avant, II a Ma College (1-4or 5+) Bank Teller Union Trust Bank 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Catherine C. Thorne Robert L. Duckett 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Roseanne Bittner/Daughter ROSEANN BUETTNER /DAUGHTER permit. Pages 1 and 2 s Department of Health ar Important: if item 27 la any injury or other trau QDG8. 14089 Monticello Drive Cooksville MD 21723 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slete 20a. Method of Disposition 1 D Burial 2 Cremation 3 Removal from State Moreland Mem. Park 1/17/04 Baltimore Maryland * 4 ☐ Donation 5 ☐ Other (Specify) Christina L. Hilton Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 21. Signature of Funeral Service Licensee histing 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) he shock Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, by Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12/months?

1 Yes 2 No
9 Unknown Month Day Year be detached for 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe this certificate 1 Tyes 2 No 1 Yes 2) No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After t Natural 5 Pending after death.

Director: Aft 1 Yes 2 No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled Hospital within 24 hours To the Funeral Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only onel the state 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 0 050870 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dane Clarksulle me Signal Bell 500 Suzan 32. Registrar's Signature 31. Date filed (Month. Day State Registrar

		1 - For State Registrar 1. Decedent's Name (First, Middle, La	State of Marylar				lealth and Death		eg. No.	04 0072
Physi		Lorraine (nm						January	Day Y	'ear
/Med Exam		4a. Facility Name (If not institution, give	e street and number)		4b. City,	Town, or	Location of Dea		4c. County of	
	3.4	Levindale Hebre				timo				
Funera Directo	_	5. Social Security Number 6. S 103–18–3255 Usual Residence of Decedent	7. Age (In yrs.	. last birthday) Yrs.	If Under Months	Days	If Under 24 Hr. Hours Mir	. (Month, Day	9, 1924 I	9. Birthplace (State or Foreign Country) New York
Maryland a-f show	tor	10a. State 10b. County Maryland Harfo:		ity, Town or Lo	_					10d. fnside City Limits 1 ☐ Yes 2 ☑No
or 28	Directo	10e. Street and Number			10f. Zip	Code		1	0g. Citizen of Wh	at Country?
ath w	rail	2027 Hanson Roa					21040			SA
be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or flame 23a or 28e-f show event, the Mcdral Examiner mant be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 [XYes 2 ☐ No If Yes, Give Year or Dates: ₩₩1]		Was Deced ff Yes, spen 1 ☐ Yes		ispanic Origin? (in, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)		American Indian, White, etc. White
72 ho	Completed	15. Decedent's E (Specify only highest gra	ducation	16a. Dece	dent's Usua	al Occup	ation	orkina	16b. Kind of Busin	
within lene. then	mpfe	Elementary/Secondary (0-12)	College (1-4or 5+)	_			during most of wo	, , , , , , , , , , , , , , , , , , ,		
id 2 should be filed within 72 hours af the and Mental Hygiene. It is marked other than "natural, or traumatic event, the Medical Exami		12 17. Father's Name (First, Middle, Last)	Bank	Mana	ger	18. Mother's Na	me (First, Middle, I	Banking	
	To Be	Oscar Nelson	Ostrander				Florence		Taylor	
To, Mal y late to a stand by the stand 2 should by the stand Menta itsm 27 is marked other traumatic events.	-	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address	(Street		lural Route Number	City or Town, St	ate, Zip Code)
		William George Ca	arson / Husban	d 2027	Hans	on R	oad, Edd	rewood, Ma	ryland :	21040
ges 1 a of Hea		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	206.	Place of Dispo cemetery, crei	sition (Nar	ne of		Date	20c. Location - Ci	ty or Town, State
permit. Pages Department of Important: If it any injury or o	1	*4 □ Donation 5 □ Other (Specia	y) Hi				Grdns 1			on, Maryland
permit. Pages 1 are Department of Hear Important: If item any injury or other		21. Signature of Faneral Service Lice	Juch		1317	Coke	sbury Ro		gdon, Mai	ryland 21009
Physiciar /Medica Examine	ı	23a. Párt1. Ente the disease, or com shock, or heart failure. List only Immediate Cause (Finat disease or condition resulting in death)	one cause on each line.	vula			1 Stase	ic or respiratory arre		Approximate Interval Between Onset and Death
death certificate be executed ettending physician and of or use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b							
the death certifica y the attending ph ched for use as th	Physician/Medical	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown	23c. ff yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o	aldeath 3[Ectopic pr Other (sp				23d. Date of Month	,
law requires that the de as been signed by the a 2 should be detached f	b	Part ff. Other significant conditions of	contributing to death but not res	sulting in the u	nderlying c	ause givi	en in Part I.		acco use contribu	ute to the cause of death? Probably 4 Monknown
The ate ha	Completed				-			24a. Was all autops perform	ned? prio	re autopsy findings available or to completion of cause of th?
cian: ertific ector,	Be	25. Was case referred to medical examiner?						ath (Check only on	э)	
	2	1 Yes 2 No		ER/Outpatier			4 🗀 Nursing I	Home 5 ☐ Reside		(Specify)
ding After funer	Certification;	27. Manuard of Death 1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not b		28b. Time of Injury	М		yes 2 □ No	28d. Describe ho		
ospital or Attant hours after death uneral Diractor:		4 Homicide determined	building, etc. (Speci	fy)				City or Town	, State)	or Rural Route Number,
24 H	edical	29a. Certifier (Check only one) 1 Certifying Properties 2 Madical Exert	nysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death ation and/or in	occurred vestigation	at the tim , in my of	ne, date and plac pinion, death occ	e, and due to the ca urred at the time, da	use(s) and manne ite and place, and	er as stated. If due to the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier			290	. License	number	29	d. Date signed (A	Month, Day, Year)
(1		1 Vaymand M	uli mo			D4	7683		1/13/	04
OXI		30. Name and address of person who				2			1	
V	1010	31. Date filed (Month, Day, Year)	25 Main Strugg	Swite ?	100 1	en ste	Thun	MD		
Reais	tate trar	JAN	1 5 2004	Carlotted of	F A					

			1 - State Amend Item Registrar	State of 25 per me	Marylan e G839	d / Depa 1-18-0	artment of H	ealth and Death	Mental Hy	giene 2	004	00727
	Physici /Medic	an	1. Decedent's Name (First, Middle, MATTH)			_(200 K		2. Date of De Month JANU	Day	7, 2004	3. Time of Death
	Examin	er	4a. Facility Name (If not institution, HARBOR	HOSPITA	H			IMIOPI	=	n	anty of Death	
	Funeral Director		5. Social Security Number 216-13-8499 Usual Residence of Decedent	6. Sex 7	. Age (<i>In yr</i> s. 25	Yrs.	If Under 1 Year Months Days	If Under 24 H		1978	Count	lace (State or Foreign try) Land
	Maryland -f show	tor	10a. State 10b. County MD n/a			y, Town or Lo					10	Od. Inside City Limits
	3a or 28e	al Direc	10e. Street and Number 5020 Biddle St.				10f. Zip Code	1205		10g. Citizen	of What Coun	try?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatile and Mental Hygiene. Department of Heatile and Mental Hygiene. Department of them 27 is marked other than "natural" or items 23a or 28e-f show many injury or other traumatic event, the Medical Examinar must be inclined at ADDG.	Completed by Funeral Director	11. Marital Status Marital Status 2 Marrie 3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 Yes 2 If Yes, Give Year or Dat	es? No		Was Decedent of Hi f Yes, specify Cuba 1 □ Yes 2□No	ispanic Origin? n, Mexican, Pue Specify:	(Specify Yes or No erto Rican, etc.)		Race - America Black, White, e ecify:	
21215-0036	l within 72 ho iene. r than "natur the Medical I	ompleted	15. Decedent (Specify only highest Elementary/Secondary (0-12)		4or 5+)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired rical Hel	furing most of w	rorking		of Business/Ind	,
Maryland 2	uld be fileo Aental Hyg rked other tic event,	To Be C	17. Father's Name (First, Middle, L Harry Cook	ast)				18. Mother's N	ame (First, Middle Kreutzb		name)	
, Mary	and 2 show alth and N n 27 Is ma er trauma		19a. Informant's Name/Relationsh Linda Kreutzber			5020	ng Address (Street a Biddle S		altimore			
Baltimore,	Pages 1 ment of He ent: If iten ury or oth		20a. Method of Disposition XX Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		lato L _C	emetery, crei	sition (Name of natory or other plac em Garden	s 01/	Date 12/2004		on - City or Tov ir, MD.	
Ball	Departition Depart		21. Signature of Funeral Service L	Coto	W	1		co Aven		edale,		and 21237
	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a. SEP	ch line.		er the mode of dying	g, such as card	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Obstace or high) that initiated events	С.	r as a conseq			A 0.1	C. BY MEDICAL	EXAMPLER		
8760,	cate be executed physician and the burial-transit	dlcal Ex	resulting in death) Last	d.	r as a conseq	uence of):	CE	TITLE STION APPL	ROVED BY MEDICA			
. Box 6	death certiff e attending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2 ☐ Feta nt at time of d	Ideath 3□	Ectopic pregnancy Other (specify)				Date of deliver Month	ry Day Year
	8 50 0	ð	Part II. Other significant conditio	ns contributing to dea	ath but not res	ulting in the u	nderlying cause give	en in Part I.	1		contribute to the	e cause of death? ably 4 DUnknown
l Rec	The law ate has t page 2 s	Completed							1 ☑ Yes	psy prmed? 2 \(\sum \) No	prior to con death?	osy findings available inpletion of cause of 2D No
Ξ	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:	patient 2 🗆	FR/Outpotion	nt 3 DOA Othe	ar	eath (Check only) Home 5 Resi		Other (Ca-+:4-	
on of	ding h. After fune	tlon: To	1 X Yes 2 No. 27. Manner of Death 1 Natural 5 Pending 2 Accident investig	28a. Date of (Month		28b. Time of Injury	28c. Injun Work	47747	28d. Describe			/
=	i i i i e	Certification;	3 Suicide 6 Could n 4 Homicide determi	ned 288. Flace	of Injury - At he g, etc. (Specif	ome, farm, str	eet, factory, office	-	28f. Location (City or To		umber or Rural	l Route Number,
1/	To the Höspitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	edical C		Physician: To the texaminer: On the base	sis of examina							
	Vithii Comp	W	29b. Signature and title of certifier		M_D		29c. License	o RES	2		gned (Month, E	7, 2004
1			30. Name and address of person of MALA SIVANA	NDY 3	001	SHA	Print)	STRE	ET, BA	LTIM	ORE, N	MD 21225
	Sta Registi		31. Date filed (Month, Day, Year)	N 1 5 2000	gistrar's signa	iture	1 Spark					

		1 - For Amend Item 24a Registrar 1. Decedent's Name (First, Middle,			061	incate	OI DCC	4177	2. Date of De	ath		-	3. Time of Death	1
Physici		Robert Geor		aig					Month January	Da 7 3.		Year	4:20 PM	M
/Medio		4a. Facility Name (If not institution,				4b. City, To	wn, or Loca	tion of Deeth	7	_	County of		-1.20 11.	
		Manor Care Ross	ville			Ross	ville				Balti	more	•	
Funeral			6. Sex	7. Age (In yrs.		If Under 1	Year If U	nder 24 Hrs. urs Min.	8. Date of Birt (Month, Da				ace (State or Fore	ign
Director		179-18-4444	18∑M 2□F	88	Yrs.	WORKING E	Jays						ylvania	
12.00		Usuel Residence of Decedent 10a, State 10b, County		10c Cit	y, Town or Lo	cation						10	Od. Inside City Lim	its
findat	2	Tou. State		100.0	,,	52.011							1 ⊠ Yes 2 🗆 I	
28a-f st	ect	MD •		Ba	altimor	10f. Zip Co	ode			10a Ci	izen of Wh	nat Count	tn/2	-
P S	ā									rog. On	12011 01 111	iat oouii	ay:	
M	Funeral Director	1000 Hewitt Wa		edent Ever in U	.S. 13. V	2120 Was Deceden		c Origin? (Sp	ecify Yes or No		USA 14. Race	- America	an Indian,	
ä	Fun	1 ☐ Never Married 2 ☑ Marrie	Armed F	orces?				xican, Puèrto	ecify Yes or No Rican, etc.)		Black,	White, e	etc.	
Tage 1	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Gi Year or D	Ve		I⊡Yes 2≹	□ No Spe	ecify:			Specify:	Whi	te	
ES	Completed	15. Decedent's			16a. Deced	ient's Usual (Occupation	most of work	rina	16b. K	ind of Bus			
Med	pie	(Specify only highest Elementary/Secondary (0-12)	College (life. I	OO NOT use	retired)	most or work	mg .					
3	Sol	12			Steel	Worke	er			1	Steel		,	
9	Be	17. Father's Name (First, Middle, L	ast) Unk.				18. N	Nother's Nam	e (First, Middle,	Maider	Sumame,) Un	k.	
atic	ျ													
27 is marked other r traumatic avent, i	1	19a. Informant's Name/Relationshi	ip (Type, Print)		F				al Route Numbe				Code)	
item 27 other tra		Betty Jo Cra	ig (wi		1000 Place of Dispo	Hewitt	-	_	imore,				um Ctata	
or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation			emetery, cren	natory or othe	er place)			20G. L	ocation - C	ity or 10	wn, State	
any injury or on once	П	`4 □ Donation 5 □ Other (Spe		Oa1	Lawn				/2004		ltimo			_
000		21. Significate of Funeral Service L	eensee		22	. Name and	Address of F	acility Duo	la-Ruck	Fune	eral	Home	oİ	
8 0		Mas a. G.							dalk, M		21222		Dundalk,	I:
		23a Part1. Enter the disease, or of shock, or heart failure. List of	only one cause on	each line.			or aying, suc	n as cardiac	or respiratory ai	rrest,			Approximate Interval Between Onset and Death	
sician		Immediate Cause Final disease or condition resulting in death)	_ a		XOJ EF	IA								
dical niner	ŀ	resoluting in dodain,	Due to	(or as a conseq								1	tours	
	-	Sequentially list conditions,	b. — Cua to	(or as a consec	CHYD werder off	4-17318	5 N							
I-transit	i i	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			SEM 6	MILL								
al-tra	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a conseq	uence of):							-		
ine burial	lical		d											
88														
2	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		itcome of pregna		Ectopic preg	inancv				23d. Date		•	
	slcia	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of o		Other (spec					Mont	n	Day Year	
	Phy	9 Unknown											4 4 4 4	
	by	Part II. Other significant condition		leath but not res		nderlying cau	se given in f	Part I.			_		e cause of death?	
pinous	ted	10/10/51	700 1	VI-20-1-CO	/ [Yes 2			ably 4 ⊟Unkno	WII
9.2 st	nple								24a. Was autop	osy	pri	or to con	sy findings availa apletion of cause of	ole of
or, page 2	Completed								1 Yes	rmed? 2 X □No		ath?] Yes	2□ No	
	Be (25. Was case referred to medical examiner?						Place of Deat	h (Check only o	ne)				
Ď.	2	1 ☐ Yes 2 ☐ No	Hospital: 1 🗆	Inpatient 2	ER/Outpatien			- Harsing Ho	ome 5 Resid	dence	6 □Other	(Specify)	
ē	ü	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date (Mor	of Injury oth, Day Year)	28b. Time of Injury		: Injury at Work?		28d. Describe	how inju	ry occurred	d		
	-	2 Accident investiga 3 Suicide 6 Could no	ot be			М	1 🗆 Yes	2 🗆 No	201 1 - 11 11					
	catic	dotormi	ned 286. Plac	e of Injury - At h ling, etc. (Speci	ome, farm, str fy)	eet, factory, o	office		City or Tov			or Rural	Route Number,	
	rtification	4 Homicide		a bast of my key	vulodoo dooti		the time de	to and alone						
the tuneral di	I Certification;		Physician, To th											
in in including	dical Certification	29a. Certifier 1 Certifying	Physicien: To the lixaminer: On the lixaminer	pasis of examina	ttion and/or in	· oonganon, n								
	Medical Certification	29a. Certifier 1 Certifying (Check only 2 Medicel E	xaminer: On the l		tion and/or in		License num	ber		29d. Da	te signed	(Month, L	Day, Year)	
in in including	edical	29a. Certifier (Check only one) 29b. Signature and title of certifier	xaminer: On the l and man	pasis of examina	tion and/or in	29c. t				29d. Da	te signed	(Month, E	Day, Year)	
the funeral di	edical	29a. Certifier (Check only one) 29b. Signature and title of certifier	xaminer: On the land man	oasis of examina nner stated.		29c. t	513	06		1	3/2	60 r	+	
leath. tor: After this the funeral di	edical	29a. Certifier (Check only 2 Medicel E one) 29b. Signature and title of certifier	xaminer: On the land man	oasis of examina nner stated.		29c. t	513	06		1	3/2	60 r	+	7

			1 - For State Registrer Amend Item 1. Decedent's Name (First, Middle, Last)	State of Maryla #9 per fh G8	and / Dan				•	giene Reg. No.	•	1 0 0 7 2 9
1	Phỳsici		TANDY N	DILLOW Jr					Month	Day	Year ZuO	Carre au
	/Medio Examin		4a. Facility Name (If not institution, give:	street and number)	PITTL		y, Town, or Loc				County of Dea	ath
	Funeral Director		5. Social Security Number 6. Sey 391-12-0410	7. Age (In y	rs. last birthday) Yrs.	Month:		Under 24 Hrs. lours Min.	8. Date of Bird (Month, Da Dec. 10	y, Year)	9. Bi	rthplace (State of Foreign Jountry Michigan Illinois
	Maryland -f show	tor	10a. State 10b. County MD Howard	10c.	City, Town or Lo Highla				,,	-		10d. Inside City Limits 1 ☐ Yes 2 🖾 No
	ith the	Oirec	10e. Street and Number			10f. Z	ip Code			10g. Citi	zen of What C	ountry?
	ath w	rai	13197 Highland Roa	· · · · · · · · · · · · · · · · · · ·			0777				S.A.	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any njury or other traumatic event, the Mudical Exacili writinal Le ixuffied at ance.	by Funerai Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 XX es 2 No If Yes, Give Year or Dates:				nic Origin? (S) flexican, Puerti fpecify:	pecify Yes or No o Rican, etc.)		14. Race - Am Black, Whi Specify: W]	ite, etc.
Baltimore, Maryland 21215-0036	thin 72 house.	Completed by	15. Decedent's Edu (Specify only highest grade	cation e completed) College (1-4or 5+)	(Give	s kind of w	ual Occupation rork done durin use retired)	n ng most of wor	king	16b. Ki	nd of Business	s/Industry
121	iled wi tygien her th		Grade 12 17. Father's Name (First, Middle, Last)		Owne	er /	Operate		ne (First, Middle,		olstery	<i>Y</i>
ryland	hould be fid Mental It	To Be	Tandy Norman Dillo 19a. Informant's Name/Relationship (Ty		19h Maili	ing Addra		Alma I				Zin Code)
Z Z	nd 2 saith an 27 is ir trau		Barbara Dillon /		1	-			Highlan			
nore,	ages 1 a ant of He it: if Rem y or othe		20a. Method of Disposition 1 ☐ Burial 2 XX remation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		Place of Dispo cemetery, crea			v Jan	Date 12, 04		cation - City or	
Baltir	permit. P Depertme Importan any njur		21. Signature of Funeral Service License	98	2	ona1	and Address of OSON Fi	Facility uneral	Home, P	.A.		
	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	cations that caused the de	eath. Do not en	ter the mo	ode of dying, su	uch as cardiac	or respiratory ar		ar y rain	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	PNGUM	MA		·					7 Days
68760,	ate be executed sysician and he burial-transit	cai Examiner	Eaguer tially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons								
	eath certificate attending phys I for use as the		IF FEMALE:	3c. If yes, outcome of prec	mancy				7.00	1		
P.O. Box	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 2 Fe 4 Pregnant at time o 9 Unknown	etal death 3	⊒Ectopic ⊒ Other (pregnancy specify)			2	3d. Date of de Month	Day Year
	w requires that been signed to should be deta	ed by PI	Part II. Dther significant conditions cor		-	underlying	cause given in	Part I.				o the causa of death?
Division of Vital Records,	The law re cate has be page 2 sho	Completed by									24b. Were a prior to death?	utopsy findings available completion of cause of
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital: 🔏				. Place of Dea	th (Check only o	ne)		
ō	Phys r this ral dir	To To	1 Yes 2 No	28a. Date of Injury	28b. Time o		28c. Injury at Work?	1 Nursing H	ome 5 Resid			ecify)
ision	Attending r death. ector: After y the fune	Certification:	1 Xatural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day Year)		M	1 🗆 Yes	2 🗆 No				10-1-11-11
<u>></u>	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		4 Homicide determined	28e. Place of Injury - Al building, etc. (Spe	cify)				City or Tow	vn, State)		ural Route Number,
/	ne Hosp 7 24 ho ne Fune detely fi	edical	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Examination	sician: To the best of my keter: On the basis of examinand manner stated.	nowledge, deat nation and/or in	th occurre nvestigation	d at the time, d in, in my opinio	late and place, in, death occur	, and due to the or rred at the time, or	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)
)	Total Total	M	29b. Signature and title of certifier	angon A	~>	2	D 369	mber)74			signed (Moni	* '
1	V	and of the property of the same of the sam	30. Name and address of person who co	mpleted cause of death (II	em 23a) (Type.	Print)	ttu KGN	T PAGE	wres			•
	Sta Registr	te ar	30. Name and address of person who con DAVLO MARVIES 31. Date filed (Month, Day, Year)	2004 Registrat's Sig	nature A	A STATE OF THE PARTY OF THE PAR	and I					

DHMH 17 Rev 1/2001

9

JANUARY

JOSEPH DAVIS

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January Pay 12 2004 **Physician** 5:14P M Charles A. Dear, Jr. /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 4 Rumford Court Unit 101 Catonsville If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months 1 MM 2 □ F June 22, 1921 Director 82 MD 218-03-0420 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23s or 28s-1 show the Medical Examiner must be notified at 1 □Yes 2 N No Director Catonsville Baltimore 10g Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Unit 101 21228 Funeral 4 Rumford Ct. death t 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed by 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 1 and 2 should be filed within 72 t. Health and Mental Hygiene. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Verizon Phone Company 12 Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Charles A. Dear, Sr. Rose Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 : Department of Health ar Important: If Item 27 le any injury or other trau Ellicott City, MD 21042 9804 Old Mill RD Robert Dear/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery01/16/2004 Baltimore, MD 22. Name and Address of Facility
Witzke Funeral Home of Catonsville, Inc.
Raltimore, MD 21228 21. Signature of Funeral Service Licensee 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheet, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MADRITION ZMONTHS **Physician** MYOCARDINE /Medical Due to (or as a consequence of): Examiner Z MONTIE CONGESTINE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine 2 MONTHS The law requires that the death certificate be executed HEART COMPLETE Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician 2 months VENTRICULAR Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year φ in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) the 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown HYPERUPIDEMIA Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 1 Yes 2 No 1 Yes Hospital or Attending Physician: funeral director, Be 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 KER/Outpatient 3 DOA Certification; To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation Natural 2 Accident м 1 Tes 2 No death. within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 . Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D50533 30. Name and address of person who completed cause of death litem 23a) (Type, Print) BOUTIMORE, WILKENS BUENUE SUTTE 300 32. Registre's Signature 31. Date filed (Month, Day, Year) State 2004 Registrar

			For State Registrar	State of Ma		Department of F Certificate of		Rec	ene 200	4 00732
	Physicia /Medic	_	1. Decedent's Name (First, Mic	ddle, Last) DA	SKOL	15164		2. Date of Death Month	Day Yes	3. Time of Death
	Examin		4a. Facility Name (If not institu Anne Av	tion, give street and number)	. 1650		or Location of Death		4c. County of D	
	Funeral Director		5. Social Security Number 888-44-5332	6. Sex 7. Ag	e (In yrs. last bin	thday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, AUG. 12,	1954 ^{9.1}	Birthplace (State or Foreign Country)
	aryland show	_	Usual Residence of Decedent 10a. State 10b. Cour		10c. City, Town					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	the Mis	Directo	MD AN	NE ARUNDEL	ANI	VAPOLIS		100	g. Citizen of What	^
	h with 23e or		407 THIRD ST	REET			21043		U.S.A.	
36	n 72 hours after death with the Maryland "netural", or Items 23e or 28e-f show edical Examiner must be notified at	by Funerai	11. Marital Status 1 Never Married 2 N 3 Widowed 4 N Divorce	If Yes Give A	•	13. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, hite, etc. WHITE
15-003	_ 22		15. Deced	ent's Education hest grade completed)		Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of work	ing 16	6b. Kind of Busine	ss/Industry
212	be filed within tal Hygiene. d other than "I evant, the Med	Completed	Elementary/Secondary (0-12	4	EN(GINEER		e (First, Middle, Ma	MARITI	ME
≘		To Be	17. Father's Name (First, Midd SIDNEY	io, Lasi)	DASI	KOVSKY /	JUDIT			ILSKER
Mary	12 should h and Men 7 is marke raumatic		19a. Informant's Name/Relation			. Mailing Address (Street			_	a, Zip Code)
	es 1 and of Health fitam 27 rother t		DAVID DASKOVS 20a. Method of Disposition			330 GRANT - Disposition (Name of by, crematory or other pla	CONTRACTOR OF THE PARTY OF THE		Location - City	or Town, State
Baltimore,	Pag nent int: f		*4 ☐Donation 5 ☐ Other		WILLOW	ILAWN	1/19/		VERNON H	
Ba	permit. Departrimporta any inju		21. Signature of Funeral Sev	Sugar		22. Name and Address 8900 REIS		OL LEVINS ROAD - P		E, MD 21208
	l ysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	ist only one cause of each li	a consequence	PArdiac				Approximate Interval Between Onset and Death M , NUTS
68760,	ficate be executed physician and is the burial-trans t	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1 c	a consequence	of):				
	The law requires that the death certificate has been signed by the attending place 2 should be detached for use as to	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death	3 ☐Ectopic pregnanc 5 ☐ Other (specify) _	у		23d. Date of Month	delivery Day Year
ds, P	juires that signed by Ild be deta	þ	Part II. Other significant cond	litions contributing to death b	out not resulting in	n the underlying cause gr	ven in Part I.			e to the cause of death? Probably 4 □Unknown
		Completed						24a. Was an autopsy performe	prior death	autopsy findings available to completion of cause of ?
Vita	icien: Sertific ector,	Be	25. Was case referred to med examiner?	Hospital:		Ott	205	h (Check only one)		
on of	Attending Physicien: r death. sctor: After this certificator, by the funeral director,	ition: To	1 (XVes 2 □ No 27. Manner of Death 1 (XVetural 5 □ Per 2 □ Accident inve	28a. Date of Inju	ary 28b. 7	Firme of 28c. Injury Wo	ry at	ome 5 ☐ Residen 28d. Describe how		pecify)
Divisi	i ji je e	Certification:	3 ☐ Suicide 6 ☐ Coi	ald not be emined 28e. Place of Inbuilding, et	jury - At home, fa lc. <i>(Specify)</i>	rm, street, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
2	e Hospital or 24 hours afte e Funeral Dir letely filled in	ledical (lying Physicien: To the best cal Exeminer: On the basis of and manner st	of examination an					
	To the I	Me	29b. Signature and title of cer	ifier	Dep	29c. Licens	se number	290	d. Date signed (Mo	onth, Day, Year)
	N		30. Name and address of pers	on who complet denuse of	death (Item 23a)	(Type, Print)	obe 54	vica 6	71017	
	Sta Registr	-	31. Date filed (Month, Day, Ye	JAN 1 5 32004	rars Signature.	J. J. Jagor	W/me	IICH C		/

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 8, 2004 **Physician** Year Margaret A. DeSantis 4:30 a^M /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist at G.B.M.C. Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/28/25 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 78 Yrs. 218-18-7759 Director Mary Land Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other treumatic event, the Mydical Examiner must be notified at once. MD Baltimore Rosedale 1 Yes No Director 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 2342 Hamiltowne Circle 21237 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Commercial Union File Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Elmer Bode Lena Knorr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William DeSantis Husband 2342 Hamiltowne Circle Rosedale, MD. 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 01/12/04 * 4 □ Donation 5 □ Other (Specify) Raspeburg, MD. ^{22.} Name and Address of Facility Cvach/Rosedale Funeral Home 1211 Chesaco Avenue Rosedale Masryland 21237 21. Sign ture of Funeral Service Licenses 23a. Part. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LAteral sclerosis aphiz **Physician** myotr years /Medical Examiner Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ed by the attending physicien and detached for use as the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 5 Other (specify) o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should Be Completed 24a. Was an autopsy performed?
1 ☐ Yes 2 ☒ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 A Other (Specify) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA 1 Yes 2 No Certification: To Division of 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospitel or Attending I within 24 hours after death.
To the Funerel Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No М investigation 2 ☐ Accident 6 Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 14 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Dey, Year) 025205 JANUARY 8, SOOY KKE 30. Name and address of person who - m, eted cause of death (Item 23a) (Type, Print) N. Charles St. Balto. Md 21204 6701 120 32. Register's Signature 31. Date filed (Month, Day, Year) 1 5 2004 Registrar

68760,	
76	
Вох	
ă	
o.	
P.O.	
Ś	
5	
Becor	
ě	
=	
Ħ	
>	
0	
n	
ision	
≥	

									Are Legible	
		1- For Amend Item 7 per State Registrar	гн, С827, bY/	14/04dhb	Cer	tificate of	Death	ientai Hy	giene 200	4 00734
Physicia		Decedent's Name (First, Middle, Last Emma Minerva	Dorsey					2. Date of De Month	Day Yea	
/Medic Examin		4a. Facility Name (If not institution, give	street and number)	+05PIT				8. Date of Bir	4c. County of Do	TIMORE
Director		Usual Residence of Decedent	M 2√2F	02	Yrs.	Months Days	Hours Min.	(Month, Da	y, Year)	Birthplace (State or Foreign Country) 2 West Viginia
he Maryla 28a-f ehov otified at	Director	MD. Baltimor	:e	10c. City, Too						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
eath with t		10e. Street and Number 7342 Gunpowder Rd.	12. Was Decedent	Ever in 11 C	12.14	10f. Zip Code 21220	0.00		USA	
be filed within 72 hours after death with the Maryland ital Hygiene. d other than "neturel; or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		11	Yes, specify Cuba	ispanic Origin? (Spinn, Mexican, Puerto Specify:	ecity yes or No Rican, etc.)	Black, W Specify:	mencan Indian, hite, etc. Thite
within 72 ho ne. than "netu	Completed	15. Decedent's Edu (Specify only highest grad		5+)	(Give k life. D	O NOT use retired	during most of work	ing	16b. Kind of Busine	ss/Industry
d be filed variated Hygie ded other to event, the	Be	10 17. Father's Name (First, Middle, Last)		S	eli .	Employed			Tavern Maiden Surname)	
nd 2 shoul alth and Me 27 ie mark ir traumati	ဥ	Robert Hovermale 19a. Informant's Name/Relationship (7) Philip G. Starkey,	infi	Law			May L. and Number or Rura ve. Dunda	I Route Numbe	er, City or Town, State	, Zip Code)
permit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "neturel", or ery injury or other traumatic event, the Medical Exampone.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F 1 □ Donation 5 □ Other (Specify)	lemoval from State	20b. Place o	of Dispos ery, crem Hil	ition (Name of atory or other plac 1 Mem. Gi	e) cdns 01/0	0ate 6/2004	20c. Location - City of Middle Ri	ver, MD.
permit Depar Impor eny in		21. Signature Funeral Service Licens 23. San art 1. Enter the disease, or some		About the D	79	22 Wise A	Ave. Dund	alk, MD		ndalk, Inc.
Physician /Medical Examiner	, ,	23a ant 1. Enter the disease, or and shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	Due to (or as		ey a of):		24 DIS			Approximate Interval Between Onset and Death
par icia	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence						
The law requires that the death certificate ate has been signed by the attending physoage 2 should be detached for use as the	by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal death		Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
		Part II. Other significant conditions cor	ntributing to death b	ut not resulting	in the und	derlying cause give	on in Part I.	23e. Did to		to the cause of death? Probably 4 □Unknown
	Completed								med? 🔎 death:	autopsy findings available completion of cause of s
ng Phys fter this neral di	atlon: To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	lospital: 1 Dinpatie 28a. Date of Injui (Month, Day	y 28b.	utpatient Time of Injury	3 DOA Othe 28c. Injury Work M 1 D	at at 2	ne 5 Resid	ne) lence 6 Other (Sp low injury occurred	ecify)
rel or rel Dir	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubuilding, etc	c. (Specify)				City or Tow		
To the Hos within 24 ho To the Fun completely f	Medical	29a. Certifier 1 Certifying Physical Exeminates (Check only one) 2 ■ Medical Exeminates (Check only one) 1 ■ Certifying Physical Exeminates (Check one) 1 ■ Certifying Physical Exeminates (Check one) 1 ■ Certifying Physical Exeminates (Check one) 1 ■ Certifying Physical Exemina	ner: On the best of and manner sta	examination ar	e, death and/or inve	occurred at the timestigation, in my op	inion, death occurre	ed at the time, o	cause(s) and manner a date and place, and du 29d. Date signed (Mor	e to the cause(s)
- > - 0		30. Name and address of person who co	mpleted cause/of de	eath (Item 23a)	(Type, P	. D ²	F 2088	76	1-4	.04
Stat	0	_	NINGER	T.D.	900	O FRANK	LIN SOU	are dr	BALTIN	PRE, 17D 2123
Stat Registra		JAN 1 5 200	4	s St.	Son	de				

		1	1 - For State Registrar	State of Marylan	d / Depa		of H	ealth ar	d Mental H			00735
	Physici /Medic Examin	al	Decedent's Name (First, Middle, La Betty 4a. Facility Name (If not institution, given the second of the s	ve street and number)		1		Location of D	2. Date of E Month Januar Death	Day 13	Yeer 2004 County of Death Anne A	3. Time of Death 8:15P M
432	Funeral Director			Sex 7. Age (In yrs. 1 ☐ M 2☑ F 83	last birthday) Yrs.	If Under Months		if Under 24	Hrs. 8. Date of B (Month, E FEB 1	irth 7 192	9. Birthp	place (State or Foreign http://
2-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene importents: If Item 27 is marked other than "natural", or Items 23a or 28e-f show simportents: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other treumatic event, the Medical Examination that be notified at ances.	sted by Funeral Director	10a. State 10b. County Flary I and Anne A 10c. Street and Number 100 Rol Park 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's E (Specify only highest gi	12. Was Decedent Ever in U Armed Forces? 1	S. 13.1	10f. Zip 10f. Zip Was Decediff Yes, spec 1 Yes 2	Code 21090 ent of His ry Cubar	panic Origin , Mexican, F Specify:	? (Specify Yes or Nuerto Rican, etc.)	lo- 1	USA 4. Race - Americ Black, White,	ean Indian, etc. hite
Maryland 21215-0036	2 should be filed within and Mental Hygiene. is marked other than "eumatic event, the Mark	o Be Completed by	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Las JOSEPh	College (1-4or 5+)	Homema				Name (First, Middi		Househol Sumame) Your	
	and 2 shoul ealth and Me m 27 is mark	10	19a. Informant's Name/Relationship Edward Death	son	311 Be	enton	Ave.	nd Number	nicum, Ma	rylan	Town, State, Zip d 21090	Code)
Baltimore,	permit. Pages 1 and. Department of Health Importent: If Item 27 any injury or other tr once.		20a. Method of Disposition 1 Bunal 2 Cremation 3 Cremation 3 Cremation 5 Other (Special Signature of Furieral Service Local Control C	Removal from State	22	matory or of emator 2. Name and	y Indicated Address	C. 1	/17/04 Stalling Road Pasac	Balt s Fun		aryland ne P.A.
760,	Physician /Medical Examiner paper pa	ical Examiner	23a. Part Enfer the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conseq Due to (or as a conseq Due to (or as a conseq Due to (or as a conseq d.	uence of):	er the mode	of dying	, such as ca	rdiac or respiratory Libl Metal	arrest,		Approximate Interval Between Onset and Death Manual
P.O. Box 68	res that the death certificate be executed igned by the attending physicien and be detached for use as the burial-transit	ysiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3	Ectopic pre				2	3d. Date of delive	ery Day Year
Vital Records, P	requi	Completed by Physician/Med	Part II. Other significant conditions Wy perd		ulting in the u	nderlying ca	ause give	n in Part I.	1 [24a. Wa	Yes 2	No 3 □ Prob	ne cause of death? pably 4Unknown psy findings available mpletion of cause of
n of Vital F	ng Physicien: The law ter this certificate has t neral director, page 2 s	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 ☐ Pending	Hospital: 1 Inpatient 2 28a. Date of Injury	ER/Outpatier 28b. Time of Injury		A Othe	r: 4 ☐ Nursi	1 ☐ Yes Death (Check only	2 X No one) sidence 6	1 ☐ Yes X Other (Specify	son home
Division of	To the Hespitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification;	2 Accident investigate 3 Suicide 6 Could not 4 Homicide determined	be 299 Blace of leiting At h	ome, farm, str	М	1 🗆 Y	es 2⊡No	28f. Location	(Street and own, State)	Number or Rura	of Route Number,
10	the Hispi hin 24 hou the Funer mpletely fill	Medical	(Check only 2 Medical Exa	hysician: To the best of my kno miner: On the basis of examina and manner stated.	wledge, deat ition and/or in	vestigation,	in my op	inion, death	lace, and due to the control occurred at the time	, date and	place, and due to	the cause(s)
		~	29b. Signature and title of certifier ### Add Company 30. Name and address of person who	D. Ronning of completed cause of death (Item	140 n 23a) (Tvpe	D	License	389	12	Zad. Date	signed (Month,	Day, Year)
0	Sta Registr		S. Dupaya Rami		78	345 Oa		d Driv	re Glen Bu	ırnie	MD 2106	1

						indelible ink. E		_	_	
			, POI	State of Ma		epartment of Hea		ental Hygiei	ne) nn!	00736
			- State Registrar			Certificate of De	ath	Reg.	No.	00100
	Physicia		1. Decedent's Name (First, Middle, Last)	HÁI	VE	IN ARTS	2	2. Date of Death Month	Day Year	3. Time of Death 6:40 A M
	/Medic Examin		4a. Facility Name (If not institution, give si	treet and number)	in Cen-	4b. City, Town, or Loc	ation of Death		4c. County of Dea	
		٠.	GREATER BALTI	MOre	Medic	AT BALT	0 Md		BALT	IMURE
	Funeral Director		5. Social Security Number 6. Sex	7. Age	e (In yrs. last birtl Y		Under 24 Hrs. 8 ours Min. (Date of Birth (Month, Oay, Ye)1-06-20(9. Bin Co Mar	hplace (State or Foreign untry) yland
-	0		Usual Residence of Decedent		40.00.7					404 1- 11- 02- 11-2-
	show	L	10a. State 10b. County		10c. City, Town					10d. Inside City Limits 1 Stres 2 □ No
	8a-f	Directo	Md N/A		Baltin			10-	Oiri of Miles O	
	Nor 2	吉	10e. Street and Number 4203 Barrington Ro	and		10f. Zip Code 21229			Citizen of What Co	suntry?
	9ath 1	Funeral		2. Was Decedent B	Ever in H.S.		nic Origin? (Speci		14. Race - Ame	rican Indian.
	Itam	Š	1, Marrial Status	Armed Forces? 1 ☐ Yes 2 € N		13. Was Decedent of Hispar If Yes, specify Cuban, M	lexican, Puerto Ri	can, etc.)	Black, Whit	
5	urs al	þ	3 Widowed 4 Divorced	If Yes, Give T Year or Dates:		1 ☐ Yes 2 No S	pecify:		Specify: B1	ack
215-0036	i within 72 hours alter death with the Maryland jene. I'then "naturel", or Itams 23e or 28e-f show I're Medical Examiner must be notified at	Completed	15. Decedent's Educ	ation	16a.	Decedent's Usual Occupation (Give kind of work done durin	n na most of working	16b	. Kind of Business	Industry
	within / ene. then "r ne Med	ple.	Elementary/Secondary (0-12)	College (1-4or 5		life. DO NOT use retired)	g most of working			
7	0 0 0	S	0			N/A		-	N/A	
	ild be file lental Hy ked oth Ic evant	Be	17. Father's Name (First, Middle, Last)			18.	Mother's Name (First, Middle, Maid	den Sumame)	
> '	should ind Men ind Men ind Men ind Men ind Men ind Men ind Men	ဥ	Nicholis Edwards				Aryne S			7.0.11
<u> </u>	~ ~ ~ ~ ~		19a. Informant's Name/Relationship (Typ	ne, Print)		Maiting Address (Street and I				
	Health Health am 27 othar tr		Aryne Scurry 20a. Method of Disposition			203 Barrington Disposition (Name of	Road Ba		Md 2122 Location - City or	
وّ	o o = ≿	1	1 Surial 2 ☐ Cremation 3 ☐ Re	emoval from State		Disposition (Name of r, crematory or other place) Memorial	01–12-		butus, M	
=			* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License		ALDUCUS					Directors In
g	permit. Departn Importe any inju		21. Signature provincial Service License			8728 Liberty				
			23a. Part1. Enter the disease, or complic	cations that caused	the death. Do no	I				Approximate
			shock, or heart failure. List only on tmmediate Cause (Final	e cause on each lir	ne.	1			,	triterval Between Onset and Death
	hysician /Medical		disease or condition resulting in death)	Due to (or as	a consequence o	EMATURITY 11:		_		= 31 +160
ı	Examiner									
		Jer	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence o	0.		-		
	rcuted nd transi	Examiner	that initiated events c.							
9	e be executed ysician and e burial-transit		resulting in death) Last	Due to (or as	a consequence o	t):				
ر ع	cate b	dlcal	_ d							
× 6	ding p	Me	IF FEMALE:	3c. If yes, outcome	of pregnancy	COLCE THE COL			and Date of del	
XO RO	leath certificate attending phys I for use as the	Physiclan/Medl	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of del Month	Day Year
o i	by the detached	ıysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown						
J	res that igned by be deta	by Ph	Part II. Other significant conditions con	tributing to death be	ut not resulting in	the underlying cause given in	Part I.	23e. Did tobacc	co use contribute to	the cause of death?
<u>8</u>	quires n sign uld be							1 ☐ Yes	2 ⊠ No 3□Pr	obably 4 Unknown
ပြု	The law requires that the death certificate tee has been signed by the attending physoage 2 should be detached for use as the	Completed						24a. Was an	24b. Were au	topsy findings available
Vital Records,	Phyaician: The lav this certificate has at director, page 2	E O	<u> </u>					autopsy performed	death?	topsy findings available completion of cause of 2 \square No
		Be C	25. Was case referred to medical	GBN	NC	26	. Place of Death (
>	nyanci iis ca direc	10 E	examiner?	ospital: 1 Inpatie	ent 2 ER/Out		4 ☐ Nursing Home	e 5 ☐ Residence	6 □Other (Spe	cify)
Division of	ding Ph h. After th funerat		27. Manner of Death 1 ⊟Natural 5 □ Pending	28a. Date of Injur (Month, Day	ry 28b. T y <i>Yeer)</i> In	me of 28c. Injury at jury Work?	28	d. Describe how in	nitury occurred	
S S	endin eath. or: Al	atle	2 Accident investigation				2 🗆 No			
\equiv	or Att ter de iract n by t	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	u ry - At home, far c. <i>(Specily)</i>	m, street, factory, office	28	f. Location (Street City or Town, St	t and Number or Ri tate)	ural Route Number,
_	urs al urs al sral D			1-1 -	-1				-(-) 1	
:	To the Hospital or Attending Physicien: within 24 hours after death To the Funarel Director: After this certifica completely filled in by the funeral director.	edical			examination and	death occurred at the time, d Vor investigation, in my opinio				
	o tha ithin 3 o tha omple	Me	29b. Signature and title of certifier			29c. License nu	mber	29d.	Date signed (Mont	h, Day, Year)
1	- s + ŏ		maria 1	Paris	-mo	D0041	15%		1/7/0	4
	_		30. Name and address of person who co	mpleted cause of d	eath (Item 23a) (Type, Print)			1-11-	•
	2		GBMC 67011	1	LES ST.	BALTIMORE	mo.	21204		
	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	,				
	Registi	ar	JAN 1 5 2004	Blacker	15 fag					

			Please 1 - State Registrar	State of Ma		d / Depa	artme		ealth and l		ntal Hy		20	0 L	0073	-/
	Physici /Medio	al	Decedent's Name (First, Middle, La Margaret A A Fecility Name (If not institution, give	nderson	F	other			Location of Deat		Date of De Month Januar	y 1		fear 04 Death	3. Time of Death 7:00 P	1
	Examir Funeral Director	er	St. Elizabeth Nur 5. Social Security Number 6. S	sing Home	e (In yrs.	last birthday) 1 Yrs.	Ва	ltimor er 1 Year		8.	Date of Birt (Month, Da	h	/A 02 S	9. Birthpli Count	ace (State or Foreig ry) .and	דען
	a-f ehow	ctor	Usual Residence of Decedent 10a. State Maryland Baltimo	re		y, Town or Lo tonsvi									d. Inside City Limit:	
	th with the 23s or 28	ai Director	10e. Street and Number 300 Stonewall Ro	ad			2	ip Code 1228				USA				
036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. "Hygiene" Hygiene 184 or 28a-f ehow marked other than "natural", or iteme 28a or 28a-f ehow matic event, the Madical Examples in that the malified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Amed Forces? 1 Yes 2 If Yes, Give Year or Dates:				edent of His ecify Cubar 2 \textstyle No	spanic Origin? (S n, Mexican, Puerl Specify:	ipecify to Ric	/ Yes or No an, etc.)	•	14. Race Black, Specify:	White, e		
9500-61212	vithin 72 ho ne. han "natur e Macical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		i+)	(Give	kind of v DO NOT	ual Occupa vork done d use retired)	uring most of wo	rking			ind of Bus		ustry	
and 2	e d a b	Be	12 17. Father's Name (First, Middle, Last)		Homem	akel		18. Mother's Nar							
Š	and 2 should ealth and Men m 27 Is marke ner traumátic	2	James Findley 19a. Informant's Name/Relationship (Charles Moore/So			4.1	•	ss (Street a	<u>Catheri</u> nd Number or Ri West	ural R		_		tate, Zip	Code)	
imore	Pages 1 nent of H ant: If ite ury or oth		20a. Method of Disposition 1	y)	1	Place of Disponentery, cree enwood				Date		20c. L	ocation - C			
Bait	permit. Departe Importe any inj		21. Signature of Juneral Service Lice Edward A.	regorchik			2900	State	s of Facility Funeral e koad	Di	rexel		1, PA	19	0026 Approximate	
	try sician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or some shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as Due to (or as	a conseq a conseq a conseq	uence of): NUM uence of):			Menti		spiratory ai	rrest,		or or	Interval Between Onset and Death Onset and Death ONLY	N
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burtal-transit	by Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Due to (or as d. 23c. If yes, outcome 1 \(\triangle	of pregna	ancy Il death 3[⊒Ectopic ⊒ Other (pregnancy specify)					23d. Date Mont		y Day Year	
ords, P	equires that en signed b ould be deta		Part II. Other significant conditions Depytes to view of the conditions of the cond	contributing to death b	ut not res	ulting in the u	nderlying	cause give	on in Part I.			obacco Yes 2			a cause of death?	n
al Records,	n: The law n icate has be r, page 2 sh	Completed									1 ☐ Yes	osy rmed? 2 No	pri de	or to con ath?	sy findings available pletion of cause of	
of Vit	Physician this certif	: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manyer of Death	Hospital: 1 Inpati		ER/Outpatie			4 Nursing I	łome	-	dence)	
Division of Vital	or Attending iter death. Director: After in by the fune	Certification:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not to determined	(Month, Da	y Year) ury - At h	Injury ome, farm, st	М	L	es 2 □ No			Street a	nd Numbei		Route Number,	
_ ン	To the Hospital within 24 hours a To the Funeral Completely filled	edical Ce	29a. Certifier 1X Certifying P. (Check only one) 2 Medical Exa	nysician: To the best miner: On the basis o and manner st	f examina	owledge, deat ation and/or in	h occurre vestigati	ed at the tim on, in my op	ie, date and place pinion, death occi	e, and urred	due to the at the time,	cause(s date an	and man d place, ar	ner as stand	ited. the cause(s)	
,	To the Compl	Me		yor WD				Pgc. License 入えつ	541			Jai		14,	2004	
	10		30. Name and address of person who GET THH RATT	completed cause of 4. 4. 32. Registr	-		Print)	Fen	3 Rd,	Be	ultini	sue	,M.	0-2	1227	
X _C	Sta Regist	ate rar	AN 1	5 2004 D	GUII	Ne Ne	A	. 19 :								

ORIGINAL

		ricase	State of Maryland	/ Departme	nt of Health and	Mental H	vaiene	
		For State	State of Maryland		te of Death	Wichtairi	Reg. No. 200	. 11738
		Registrar 1. Decedent's Name (First, Middle, Last)	Oortmoa		2. Date of D	eath	3. Time of Death
Physici		Lillian	T Food			Month	- 02 - 2	MA 0100 AM
/Medic Examin		4e. Fecility Name (If not institution, give	street and number)	4b. City	, Town, or Location of Dea	ath	4c. County of Dee	oth
	•	Johns Hookin	S Bayvie	W 13	al time	e	NA	
Funeral		5. Social Security Number 6. Se		Months	er 1 Year If Under 24 Hr Days Hours Mir		Dav. Year) 🗸 📗 C	rthptece (State or Foreign ountry)
Director		Usual Residence of Decedent	34 × 59	Yrs.		PAPR. 1	1914 1	7147.
land		10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Limits
Mary Feb	ţ	MIT. NA	BAC	TIMERE	<u> </u>			1 No 2 No
h the	lrec	10e. Street and Number	14	10f. Z	ip Code		10g. Citizen of What C	ountry?
death with the Maryland ms 23a or 28a-f ehow I must be motified at	a D	9115. LINWE	OD	· ·	2/224		0.51	4
	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Dec	edent of Hispanic Origin? (ecify Cuban, Mexican, Pue	(Specify Yes or I erto Rican, etc.)	No- 14. Race - Am Black, Wh	
.UU3b hours after death with the Marylan tural; or items 23a or 28a-f ehow al Examiner must be rediffed at	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes	No Specify:		Specity:	1.3.4.
? č 2 a	ted t	15. Decedent's Edi	ucation	16a. Decedent's Us	ual Occupation		16b. Kind of Business	s/Industry
vithin 72 hc ene. then "natur	piet	(Specify only highest grad Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give kind of v	vork done during most of w use retired)	rorking	.,	
	Completed	12		HOME	MAKER		own H	ME
land Id be file ental Hy ked oth	Be	17. Father's Name (First, Middle, Last)				11	le, Maiden Sumame)	
	2	19a. Informant's Name/Relationship (7	ER	10h Mailine Addro	ss (Street and Number or I	14 KOF		Zin Code)
Tra Tra		19a. Informant's Name/Helationship (1	VPS. PHILI	411 - F	/ 1	AVE B	BAITE IND	7.17.212
- c = n -		20a. Method of Disposition	20b. Plac	ce of Disposition (N	ame of	Date	20c. Location - City o	r Town, Stete
Baitimore, Dermit. Pages 1 a Department of Hes Important: If item any injury or othe		Burial 2 Cremation 3 C	Removal from State	netery, crematory of	1 and MATA	2004	BALTE M	D
Baitimo permit. Page. Department o Important: If eny injury or once.		21. Signature of Funeral Service Licen	17'	22. Name	and Address of Facility	-	1201210	9
D FOR S		Howard.	Aparla 1.	252	9 HOSEN 51	BAUT	TO-, MD 3	1224
		23a. Part1. Enter the disease or comp shock, or heart failure. List only	lications that caused the seath.	Do not enter the m	ode of dying, such as cardi	ac or respiratory	arrest,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	a CORONANY					Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):				
- LAGITITIES	ų,	Sequentially list conditions,	b. HYPERTEN Due to (or as a conseque					
ed ist	ulu	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ince or).				
760, be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conseque	ince of):				
760, ite be executed ysician and ne burial-transit	cal		d					
th cer endin	an/N	23b. was decedent pregnant	23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal d		pregnancy		23d. Date of de Month	elivery Day Year
P.O. BOX nat the death cer d by the attendir etached for use	Sick	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time of dea 9☐ Unknown				- Month	Day 1 Gai
P.C	by Physician/Med	9 Unknown Part II. Other significant conditions or	antributing to death but not result	ting in the underlying	cause given in Part I	23e Die	d tobacco use contribute	to the cause of death?
ds, signe	d by		s Disease	ang ar aro andonym	, oddoo girori iiri dici.			robably 4 Unknown
y requ	ete		3			24a. W	as an 24h Were s	utopsy findings available
a so	Completed					au pe	topsy prior to rformed?/ death?	completion of cause of
Division of Vital Records, to attending Physicien: The law requires thater death. Director: After this certificate has been signed in by the tuneral director, page 2 should be d	ပိ	25. Was case referred to medical			26 Place of D	1 ☐ Yes leath (Check ont		s 2 INO
Vil sicia s cert direct	ToB	evaminer?	Hospital: 1 ☐ Inpatient 2 🗷 E	R/Outpatient 3			sidence 6 Other (Sp	ecify)
g Phy gerthi		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?		e how injury occurred	
mdin ath. or: Aft	atlo	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		М	1 ☐ Yes 2 ☐ No			
irecte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)		ory, office		(Street and Number or F Town, State)	Rural Route Number,
Dital of urs af								
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as it	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exam	ysician: To the best of my know liner: On the basis of examination and manner stated.	ledge, death occurre on and/or investigati	ed at the time, date and pla on, in my opinion, death oc	ice, and due to the curred at the tim	ne cause(s) and manner a e, date and place, and du	is stated. ie to the cause(s)
o the ithin o	Med	29b. Signature and title of certifier	ung mannor states.	2	29c. License number		29d. Date signed (Mor	nth, Day, Year)
-358		. 11	tesel mi)		D 005695	7	1-2-0	4
h		30. Name and address of person who	completed cause of death (Item 2	23a) (Type, Print)		•		
		William T HOS			STERN AVE	BACKM	ore, mb di	224
	ate	31. Date filed (Month, Day, Year)	32. Registrar's agnatu	ıre	£.			
Regist		JAN	1 5 2004 Man	as the	parts -			
DHMH 17 Rev 1/	2001			e de	1000			

ORIGINAL

			For State Registrar	State of N	Maryland		artment tificate					Reg. No	ZIIIII	00739
1 6	Physici /Medit		1. Decedent's Name (First, Middle, La Josephine L.		no						2. Date of De Month Januar	Da	y Year 3, 2004	3. Time of Death 8:30 p M
	Examin	er	4a. Facility Name (If not institution, gi Manor Care Tows	on					Location o	n	-	В	County of Death	9
u Šķ	Funeral Director		219-05-8165	Sex 1 M 2 N F 7. /	Age (In yrs. lasi 8	t birthday) 7 Yrs.	If Under Months	Days	If Under 2 Hours	Min.	8. Date of Bird (Month, Da Apr 27	y, Year)	9. Birth Cou 9.16 MD	place (State or Foreign untry)
	Maryland f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Baltim	ore	10c. City, 1	fown or Lo								10d. Inside City Limits 1 ☐ Yes 21 ☑ No
	vith the	Direc	10e. Street and Number				10f. Zip						tizen of What Cou	
36	be filed within 72 hours after death with the Maryland ital Hyglene. d other than "natural", or tlems 23e or 28e-f show event, I'm Medical Evairate artified at	by Funeral Director	2707 Maple Avenu	12. Was Deceder Armed Force 1 Yes 2 If Yes, Give Year or Dates	No		212 Was Deced f Yes, spec	lent of Mis	spanic Origin, Mexican	gin? (Spec i, Puerto P	cify Yes or No Rican, etc.)		14. Race - Amer Black, White	ican Indian, , etc.
Maryland 21215-0036	filed within 72 hou Hygiene. wher than "natura ant, vip wedical E	Completed	15. Decedent's E (Specify only highest g Elementary/Secondary (0-12)	Education rade completed) College (1-40		(Give life. L	ient's Usua kind of wor DO NOT us	rk done di e retired)	tion u <i>ring m</i> ost	of workin	g		Whit Gind of Business/H Vling	
yland 2		To Be C	17. Father's Name (First, Middle, Las Dominic Venezi		,				18. Mothe		(First, Middle, tia	Maiden	n Sumame)	
	d 2 shu th and ?7 lem traum	3.5	19a. Informant's Name/Relationship Raynette Fiorent				_					-	or Town, State, Zi MD 21214	
Baltimore,	of H		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec		e cem	e of Dispo etery, cren	sition (Nam matory or or ake Cr	ne of ther place)	Da J	an 16 004	20c. Lo	ocation - City or T	own, State
Balt	permit. Page Department of Importent: If eny injury or		21. Signature of Funeral Service Lice	ensee 1	BPOUN		Name and Crema 8717	tion	and	Fune	ral Al s Driv	tern e E	natives Baltimore	e, MD
	Physician /Medical		23a. Can1 Enter the disease, or conshock, or heart failure. List ont Immediate Cause (Final disease or condition resulting in death)	y one cause on each	ed the death. line.		er the mode	e of dying	, such as	cardiac or	respiratory ai	rrest,		Approximate Interval Between Onset and Death
The state of the s	Examiner	L	1	~	is a consequer	nce of):						***		loyer
8760,	ate be executed thysician and the burial-transit	al Examiner	Sequentially list conditions, if any, teading to immodate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Vi	ral	nce of):	epa	i H.	ı					SyRs.
P.O. Box 687	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Unknown		2 Fetal de at time of deat	eath 3	Ectopic pro Other (sp						23d. Date of deliv Month	rery Day Year
	v requires that been signed by should be deta	by	Part II. Dther significant conditions	contributing to death	but not resultin	ng in the ur	nderlying ca	ause give	n in Part I.		23e. Did to			the cause of death? bably 4 Unknown
Il Records,	The law recate has been page 2 sho	Completed								_			prior to co	opsy findings available ompletion of cause of
Vital	ysician: J is certifica director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 → 1	Hospital: 1 ☐ Inpa	tient 2□ER	VOutpatien	t 3 DO	A Othe			(Check only o		6 ☐Other (Speci	ífv)
sion of	ding Ph I. After th funeral	ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	on	-	Bb. Time of Injury		8c. Injury Work		21	8d. Describe h			<i></i>
Division	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 286. Place of	njury - At home etc. <i>(Specify)</i>	ə, farm, stro	eet, factory	, office		2	8f. Location (5 City or Tov			al Route Number,
+	the Hospitel hin 24 hours a the Funerel I npletely filled	Medical	29a. Certifier (Check only one) Certifying F	Physician: To the beaminer: On the basis and manner	of examination	adge, death n and/or inv	occurred a vestigation,	at the time in my op	e, date and inion, deat	d place, ar th occurre	nd due to the d at the time,	cause(s) date and) and manner as s d place, and due t	stated. to the cause(s)
	To the composition of the compos	Σ	29b. Signature and title of certifier					License	number 5.7	740	t .	29d. Da	te signed (Month,	
(<u>1800</u>)	3		30. Name and address of person who	. Wiley	ME	7	Print) 3008	C	hesle	er R	we e	31317	ince mo	21234
3	Sta Registi	ride:	31. Date filed (Month, Day, Year) JAN 1 5 20	Regis	strar's Signature		of s							

Registrar

Fielding

		20	For State Registrar	State of Man	•	partment of lertificate of		F	Reg. No. ZUU	4 00741
	Physicia /Medic Examin	al .	Decedent's Name (First, Middle, Lase ARLE ARLE A. Facility Name (If not institution, give	JULES	F	REED 4b. City, Town.	or Location of De	2. Date of Dea Month	Day Ye 4c. County of D	3. Time of Death
	Funeral Director		5. Social Security Number 6. S. 216-16-1466 1 Usual Residence of Decedent	9x	In yrs. last birthd Yrs	Months Davs	If Under 24 Hours Mi		N/A 7, Year) 9. 1923	Birthplace (State or Foreign Country)
	e Maryland la-f show	ctor	10a. State MD BALTIMORI	11	oc. City, Town o BALTIMOF	Location E				10d. Inside City Limits 1 Yes 2 No
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked other than *natural', or Itema 23a or 28a-f show appring yor other traumatic avent, the Medical Examinat must be notified at once.	Funeral Director	8 POMONA SOUTH AP 11. Marital Status 1 Never Married 2 Married	12. Was Decedent Eve Armed Forces? 1 Tyres 2 No If Yes, Give	er in U.S.	10f. Zip Code 21208 3. Was Decedent of If Yes, specify Cub			Black, V	t Country? American Indian, White, etc.
Maryland 21215-0036	d within 72 hours giene. or than "natural", the Wedical Exa	Completed by	3 Widowed 4 Divorced 15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 12	Year or Dates:	16a. De	ecedent's Usual Occu live kind of work done e. DO NOT use retire _ESMAN	nation	rorking	16b. Kind of Busine	
yland	should be filed nd Mental Hygin marked other amatic event, I	To Be C	17. Father's Name (First, Middle, Last) JEROME			FREED	EDYTHE	ame (First, Middle.	GREENI	
	and 2 shi lealth and m 27 Is m		MRS. DOROTHY FREE	D/WIFE	8 PC	ailing Address (Street DMONA SOUT sposition (Name of				208
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot		20a. Method of Disposition 1 ABurial 2 Cremation 3 4 Donation 5 Other (Specification 21. Signature of Funeral Service Licents)	Removal from State	BET#ººJA(22. Name and Addr.	ess of FacilityS(14, 2004)L LEVINS(FINKSBUR ON & BROS	G,MD . INC.
	Physician /Medical Examiner	Examiner	23a. Part 1. Enter the disease, or composhock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, is any, reasing to immediate cause. Enter Underlying Cause (Disease or injury	a. Due to (or as a color to the color to th	e death. Do not		ng, such as cardi			Approximate Interval Batween Onset and Death
Box 68760,	death certificate be executed e attending physicien and of for use as the burial-transit	edical	that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant	Due to (or as a c d. 23c. If yes, outcome of	pregnancy				23d. Date of	delivery
P.O. Bo	0 0 0	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □ Live birth 2 [4 □ Pregnant at tirr 9 □ Unknown		3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	;y		Month	Day Year
	quires that in signed t uld be det	by	Part II. Other significant conditions of MECAND MX	ontributing to death but r	not resulting in th	e underlying cause gi	ven in Part I.	23e. Did to	N. 4	e to the cause of death?] Probably 4 □Unknown
Vital Records,	i: The law requires that the cate has been signed by the page 2 should be detache	Completed	BREAST C	ANCER	SP	LEPT 1	MASTA		sy prior med? deat 2 No 1 🗆	e autopsy findings available to completion of cause of h? Yes 2 \(\) No
o o	Attending Physician: I reath. If death. ector: After this certifica	tion: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 XInpatient 28a. Date of Injury (Month, Day Y	28b. Tim	e of 28c. Inju	her: 4 Nursing		ence 6 Other (S ow injury occurred	Specify)
Division	To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (r - At home, farm (Specify)	, street, factory, office		28f. Location (S City or Tow		r Rural Route Number,
1	To the Hospital or A within 24 hours after To the Funeral Direction Completely filled in b	Medical		ysician. To the best of a niner: On the basis of ex and manner stated	kamination and/o		opinion, death oc	curred at the time, o		due to the cause(s)
)	2 € § 5 8		Shen A	Hastr	ni M.	0 02	464	8 (01-12-	- 1.
	Sta	ite	30. Name and address of person who 31. Date filed (Month, Day, Year)	32. Registar's	3900	LOCH	CAVEL	BUD	13/12/11	21218

			For	State of Maryland /	Department of Health	and Mental Hygier	ne
		•	1 - Stata Registrar		Certificate of Deat		2001 00710
	Physici	an	1. Decedent's Name (First, Middle, Lasi		^ ^	2. Date of Death Month	Day Year 3. Time of Death
	/Medic	al	to Facility Name (If not institution also		4b, City, Town, or Location	January Tanuary	10 2004 4:45 PM 4c. County of Death
	Examin	er	4a. Fecility Name (If not institution, give	-1 110	4b. City, Town, or Location		A//A
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. ast		der 24 Hrs. 8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign
	Director		218-44-3330 11	JM 2XF / Q3	Yrs. Months Days Hour	S Min. (Month, Day, Year)	98 Alabama
	and **		Usual Residence of Decedent 10a. State 10b. County	10c, City, Te	ewn or Location		10d. Inside City Limits
	Maryli f sho	ō	MAN	10	ROUTO		Yes 2□No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel; or Items 23e or 28e-f show any injury or other treumatic svent, the Modical Examinar must be notified at 80ce.	Funeral Director	10e. Street and Number	1	10f. Zip Code	10g.	Citizen of What Country?
	th with	a D	1517, Druis	HIII Have	- 21	211	U.S.H
	lems lems	nner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic If Yes, specify Cuban, Mexi	Origin? (Specify Yes or No- can, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	rs afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Spec	ity:	Specify: BACK
215-0036	eture	ed t	15. Decedent's Edi	ucation 16	Sa. Decedent's Usual Occupation	16b.	Kind of Business/Industry
215	hin 72 9. 9n "ne Medi	Completed	(Specify only highest grad	de completed) College (1-4or 5+)	(Give kind of work done during m life. DO NOT use retired)	nost of working	1.
2	filed with Hygiene other the	Con	1/2		Mome ma	uler !	Domestic .
and and	ould be fil Mental H arked ott atic sven	Be	17. Father's Name (First, Middle, Dast)	Visera -	18. Mo	other's Name (First, Middle, Maid	en Sumame)
Maryland	should and Men marke umatic	ဥ	Info ant's Name/Refationship (T	ivne Print)	9b. Mailing Address (Street and Nur.	mber or Rural Route Number Cit	y or Town State Zin Code)
Ma	and 2 sho saith and n 27 is mu		The town	ENSON NUK S	5824 Leth	Walk B	21239 Nu 21239
ē,	es 1 and of Health fitem 27 r other tr	1	20a. Method of Disposition	cioma	of Disposition (Name of trematory or other place)	Date 20c.	Location - City or Town, State
E	Pages nent of I ent: If its iry or o		1 Burial 2 □ Cremation 3 □ Cremation 3 □ Cremation 5 □ Other (Specify,	Removal from State	14W OOX	1-16-04 /) IRAINA
Baltimore,	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licens	see / · //	22. Name and Address of Fa	cility HOWELL	-Unene Home
	2012		Hose m	· Amith	4600 he	138874 HZ	13alTO NO 2120
			shock, or heart failure. List only of	one cause on each line.	o not enter the mode of dying, such	as cardiac or respiratory arrest,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Myacas	did Infa	refilm	
н	Examiner			Due lo (oves a consequenc	ce or):		
		Jer	Sequentially list conditions, if any, leading to immediate cause. Ener Underlying Cause (Disease or injury	b. Due to (or as a consequence	ce of):		
	rcuted nd transit	Examlner	triat initiated events	C			
,092	ate be executed hysician and the burial-transit	Ē	resulting in death) Last	Due to (or as a consequent	ce of):		
—	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edical		d			
Box 6	leath certific attending pl	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy			23d. Date of delivery
-	death e atte	iclaı	in the past 12 months? 1 □ Yes 2 No	1 Live birth 2 ☐ Fetal dea 4 Pregnant at time of death			Month Day Year
P.0	that the de ned by the a detached f	Physiclan/M	9 🗆 Unknown	9□ Unknown			
	res tha igned be det	by	Part II. Other significant conditions co	ontributing to death but not resulting	g in the underlying cause given in Pa		o use contribute to the cause of death? 2 □ No 3 □ Probably 4 🔯 Únknown
Records,	w require been si should I	Completed	- Respirator	Y ACIDOSIS	•	1 □ Yes	
Sec.	e law has b	ηdμ	- Diabete	· ·		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of death?
a	n: Th ficate or, pag		25. Was case referred to medical		00 DI	1 Yes 2 1	
Vital	Physicien: this certificatal director, I	To Be	avaminar?	Hospital: 1 ☐ Inpatient 3 ☑ ER/	Othor	ace of Death <i>(Check only one)</i> Nursing Home 5 Residence	6 ∏Other (Specify)
ا م	ig Phy ter thi		27. Manner of Death		o. Time of 28c. Injury at Work?	28d. Describe how in	
Sio	Attending r death. sctor: After	atlc	2 Accident investigation		M 1 ☐ Yes 2		
Division	or Att	rtific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	, farm, street, factory, office	28f. Location (Street City or Town, St.	and Number or Rural Route Number, ate)
L.,1	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical Certification:	29a. Certifier 1 Certifying Phy	/sician: To the best of my knowled	dge, death occurred at the time, date	and place, and due to the cause	(s) and manner as stated
7	24 ho	dica	(Check only 2 Medical Exam	iner: On the basis of examination and manner stated.	and/or investigation, in my opinion, o	death occurred at the time, date a	and place, and due to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	/	29c. License number	er 29d. [Date signed (Month, Day, Year)
	1		1/1	Khosrow Tak	assi 0463	56 Jun	vey. 10,2004
			30. Name and address of person who o	empleted cause of death (Item 23:	a) (Type, Print)	DIA 7	ban An
		to	31. Date filed (Month, Day, Year)	32. Registrar's Signature	with Man	o Dul 1	Such 12.
	Sta Registi		JAN	V 1 5 2004 Marc	a & Spelle		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] State
Registrar Amend Item #20b per fh G827 Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 3 Month **Physician** January 2000 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Mercy_Hospital Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Days 1**2** M 2□ F Months Hours Min. 218-18-8248 88 Director 06 11 15 MD Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location il Hygiene. other then "neture!", or Iteme 23a or 28a-f show vent, the Medical Exerciper must be notified at 10b Counts 10d. Inside City Limits 1 Yes 2 No Director MD NA Baltimore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Completed by Funeral 21223 400 Millington Ave Apt 416 U.S.A. Peges 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
Int: If Item 27 Is marked other then "neturel", or Iteme 23, marry or other theurals event, the Medical Examine man 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. W Wever Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cook 6th grade na Mercy Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Alfred Gladden Victoria Gladden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Armstrong-Neice 6110 Meadow Ave, Baltimore Md 21207 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State King Memorial Park
King Memorial Park
King Memorial Park
King Mer Siral Park
1/16/04 Randallstown, 1 MBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Department of Importent: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licensee March F/H West -1606C 4300 Wabash Ave, Baltimore Md 21215 0 23a. Part 1. Enter the disease or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final / disease or condition resulting in death) U MONARU Physician /Medical Due to (or as a consequence of): Examiner 10 ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off. Examiner or Attending Physicien: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760, the attending physicien Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy detached for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown à cate has been signed page 2 should be det Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? ۵ Division of Vital Records, pertensur bemar pez troph 1055WA C 1 ☐ Yes 2 ☐ No 3 Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy perform 1 ☐ Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 patient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA dir Certification: To 27. Manner of Death 1 Zhiatural 28a. Date of Injury (Month, Day Year) uneral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending 1 Accident 1 ☐ Yes 2 ☐ No To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A death. investigation filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D37 mall 2004 30. Name and address of person who completed rause of death (Item 23a) (Type, Print) lace 21202 evins 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death GEARHEART **Physician** 3:39 JAZZMUNE 2004 JANUARY /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE CITU If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 6. Sex Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1□M 2∏F 5 Director 385 21 7732 Feb. 8, 1998 Michigan Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral', or itams 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Middle River the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4051 Rustico Rd. 21220 USA death Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates: "natural", and Hygiene.

of other than "natural event, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) n/a n/a 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be of Health and Mental Hitem 27 is marked of Gearheart Nelson James Pamela Jean 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Jean Nelson (mother) 4051 Rustico Road Middle River Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If ite any njury or of once. 1 Burial 2 □ Cremation 3 □ Removal from State Glen Haven Mem. Park 1/16/04 Glen Burnie Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home PA 21. Signa ure of Funeral So. 1407 Old Eastern Avenue Essex Maryland 21221 plications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause of each line. 23a. Part . Enter the disease, or cor sheek, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition SEPSIS Physician resulting in death) /Medical Due to (or as a consequence of): Examiner IVER DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a co sequence of) Box 68760, Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ORGAN MULTISYSTEM 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an has autopsy performed certificate 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes No Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient 2 2 ER/Outpatient 3 DOA this 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funerel Director: completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0058266 who completed cause of death (Item 23a) (Type, Print) MARK KAYTON GOO NORTH WOLFE STREET, BALTIMORE MARYLAND 31. Date filed (Month, Day, Year) State JAN 1 5 2004 Registrar

		For State Registrar	State of Marylai	nd / Depa	artme		and Me	ental Hygi		00745
Physicia /Medic	al	Decedent's Name (First, Middle, Last) Dorothy Ann Ann Ann Facility Name (If not institution, give seems)		Griswo]		r, Town, or Location		2. Date of Death Month January	Day Year 13, 2004 4c. County of Death	3. Time of Death
Examin Funeral Director	er	Mariner Health of 5. Social Security Number 6. Sex	Forest Hill	last birthday) Yrs.	For	est Hill er 1 Year If Unde	r 24 Hrs.	8. Date of Birth (Month, Day, NOV . 20,	Harford Year) 9. Birthy Cour	place (State or Foreign itry)
7.72 hours after death with the Maryland 7.72 hours after death with the Maryland 7.84 hours 23e or 28a-f show	sted by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Harford 10e. Street and Number 2210 Melrose Lane 11. Marital Status 1 Never Married 2 Marned 3 Widowed 4 Divorced (Specify only highest grade	12. Was Decedent Ever in I Armed Forces? 1Yes_ 2No If Yes, Give Year or Dates:	16a Dece	11 10f. Z	ual Occupation	rigin? (Spec an, Puerto R	ify Yes or No- lican, etc.)	g. Citizen of What Cour USA 14. Race - Americ Black, White,	10d. Inside City Limits 1 □ Yes 2 □ No ntry? can Indian, etc.
be filed within that Hygiene. od other than event, the Myselle.	To Be Completed	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) Frank Henry	College (1-4or 5+) Kendall		do not Homen	18. Moth		(First, Middle, M	Own Hom aiden Sumame) Comfurd	ne
TE, Mary	. 8	19a. Informant's Name/Relationship (Ty	ughter)	2210 Place of Disponentery, cre-	Melrosition (Namatory or	rose Lane	Fores	t Hill I	City or Town, State, Zip Maryland 21 Oc. Location - City or To	050
permit. Pages Department of Important: If is any injury or		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 23a. Part1 = Inter the disease, or company or heart failure. List only or	Ho	Bi	2. Name a ruzdz 407 (m Gardens and Address of Faci zinski Fur Old Faster	neral rn Ave	Home PA	sex, Maryla	
Physician /Medical be executed by physician and Examiner as the privat-transit	dical Examiner	shoof, or heart failure. List only or Immedia Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consection) Due to (or as a consection) Due to (or as a consection) Due to (or as a consection)	quence of): cutive quence of);	5	Jenlin	e one		4	Interval Between Onset and Death
death cert	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3[⊒Ectopic ⊒ Other (s	pregnancy specify)			23d. Date of delive Month	ery Day Year
w requires that the been signed by the should be detached	by	Part II. Other significant conditions con	ntributing to death but not re	sulting in the u	inderlying	cause given in Part	1.		acco use contribute to the	· · · · · · · · · · · · · · · · · · ·
The la The la ate has page 2	e Completed	25. Was case referred to medical				00.00			ed? prior to condeath?	psy findings available mpletion of cause of 2 No
ding Phys h. After this funeral di	Certification; To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of M	OA Other: 4 N 28c. Injury at Work? 1 Yes 2	lursing Hom 28	3d. Describe how 3f. Location (Stre	ice 6 Other (Specify injury occurred	
UNISION To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	edical Certi	29a. Certifier 1 Certifying Phy: (Check only 2 Medical Exami	building, etc. (Special Special ify)	th occurre	d at the time, date a	and place, ar	City or Town, nd due to the cau d at the time, dat	use(s) and manner as si	tated. the cause(s)	
To the I	Medi	29b. Signature and title of certifier	and manner stated.		2	9c. License number		29	d. Date signed (Month,	Day, Year)
Sta Registr		30. Name and address of person who co		5 4		cpna.	63.	clair	MO	

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 4:46 A Charles F. Gensler, Jr. 9. January 2004 /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cumberland Allegany Memorial Hospital If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☑ M 2 □ F April 4,1931 Pennsylvania Director 213-28-2872 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show 7 is marked other than "natural", or items 23s or 28s-f shov traumatic event, the Modical Examinar mat be notified at 1 Yes 2 No Abingdon Harford Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21009 United States 2042 Clarkson Drive Completed by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. int: If item 27 is marked other than "naturel", or Ite 1 ⊠Yes 2 □ No 1 Never Married 2 Married If Yes. Give Year or Dates: 1947-49 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. 3 ₩ Widowed 4 Divorced White Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Steel Industry 8 Years Foreman 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Anne E. Greene Charles F. Gensler, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2042 Clarkson Drive Abingdon, Maryland 21009 Terry Staton (Daughter) other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department Important: If eny injury or Meadowridge Mem. Park Cem. 1/12/1004 Dorsey, Maryland 1.4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of weral Service on 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Part 1. Enter the disease, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition congestive heartfailure and Chronic <24 hours acute **Physician** resulting in death) /Medical Examiner 25 years Chronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed the attending physician and ned for use as the buriat-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy 1 live birth Month Dav Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Yes 2 No 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this After thi 27. Manper of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28d. Describe how injury occurred 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and itle of certifier 2004 D16041 January 30. Name and address of berson who completed cause of death (Item 23a) (Type, Print) Memorial Hospital Medical Bldg., Cumberland, MD Terry Williams, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2004 Registrar 5

Kashya Green 04-0202 AKG

Baltimore, Maryland 21215-0036

within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

	_	- negistral Attention Trella	23a,27,Per ME,G82	28,2/13/04G	ate of Death		Reg. No.		
hysicia /Medic		1. Decedent's Name (First, Middle, Las	/	Kashiyah ah Greeh	Rakiala Green	2. Date of De Month Januar		2004^{Year}	3. Time of Death 9:49 A
xamin		4a. Facility Name (If not institution, give St. Agnes Hospita			City, Town, or Location of Dea	th	4c.	County of Death	A
neral ector		5. Social Security Number 6. Se		Ast birthday) If Ur Yrs. Mont	nder 1 Year If Under 24 Hr ths Days Hours Mir		th ay, Year) 200	Goy	place (State or Fore ntry)
ahow	or	Usual Residence of Decedent 10a. State 10b. County Maryland NA	10c. Cit	y, Town or Location	Ballimore				10d. Inside City Lim
a or 28e- I be notifi	Director		Hs Ave #300	1St A. 101	. Zip Code Z1215	-	10g. Citiz	zen of What Cou	ntry?
item 27 is markad other than "natural", or items 23e or 28e-f ahow other traumatic event, the Mudical Exama nor must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		ecedent of Hispanic Origin? (specify Cuban, Mexican, Pue es 2 PNo Specify:	Specify Yes or No rto Rican, etc.)		14. Race - Ameri Black, White, Specify:	
ir than "natur I've Medical E	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		16a. Decedent's I (Give kind o life. DO NO	Usual Occupation f work done during most of w T use retired)	orking	16b. Kir	nd of Business/Ir	ndustry
rkad otha tic event,	To Be C	17. Father's Name (First, Middle, Last) Eric Green.				ame (First, Middle		Sumame)	
27 Is		19a. Informant's Name/Relationship (7 Sherrise Myer	S-Mother	19b. Mailing Add	ress (Street and Number or F Pak Height	Rural Route Numb	er, City or	Town, State, Zij	Himore in
Importent: If item any injury or othe once.		20a. Method of Disposition 1 Serial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	Place of Disposition cometery, crematory	or other place)	Date 1404	But	cation - City or Thin ore - C	own, State
mporte any inju pnce.		21. Signature of Funeral Service Licen	see.	1 22 Nam	The second secon	V. 21.	4 .	1 0 00 1	1
- a a		23a Part 1 Enter the disease or come	KW/	3512	Frederick a	Ave. Ba	Hin	ore Man	Approximate
sician edical	1	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	olications that caused the deat one cause on each line. a. Sudden Infant Due to (or as a conseq	3512 th. Do not enter the t Death Synd juence of):	Frederick a	Ave. Ba	Hin		Approximate Interval Between
sician edical miner	dical Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	plications that caused the death one cause on each line. a. Sudden Infant	th. Do not enter the Death Syndiquence of):	Frederick a	Ave. Ba	Hin		Approximate Interval Between
attending physician and including physician and including including the purial-transit including the property of the purial-transit including the property of the purial-transit including the	<u>a</u>	23a. Part1. Enter the disease, or compshock, or heart failure. List only disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underfying Cause (Disease or injury that intitated events	a. Studden Infant Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	th. Do not enter the Leath Synd (uence of): (uence of): (uence of): (uence of): (uence of):	Frederick a	Ave. Ba	rest.		Approximate Interval Between Onset and Death
y the attending physician and ached for use as the burial-transit ached for use ached for us	by Physician/Medical	23a. Part1. Enter the disease, or compshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	b. Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	Death Syndiuence of): uence of): uence of): ancy al death	FIRACTICK 7 mode of dying, such as cardi	Ave . Baac or respiratory a	tobacco u	23d. Date of delive Month	Approximate Interval Between Onset and Death Death Onset and D
has been signed by the attending physician and under the standing physician and under the buriar-transit under the buriar-transit under the under	Completed by Physician/Medical	23a. Part1. Enter the disease, or compshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	Death Syndiuence of): uence of): uence of): ancy al death	FIRRE INC. A mode of dying, such as cardi	23e. Did 1 24a. Wa. auto	tobacco u Yes 25 s an pry pry pry pry pry pry pry pry pry pry	23d. Date of delive Month See contribute to the Second Se	Approximate Interval Between Onset and Death Death Onset and D
certificate has been signed by the attending physician and upon in both in a point of the b	o Be Completed by Physician/Medical	23a. Part1. Enter the disease, or compshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a consequence) Due to (or as a consequence)	Death Syndiuence of): uence of): uence of): ancy al death	mode of dying, such as cardinated as cardina	23e. Did 1 24a. Was auto perfi	tobacco u Yes 25 s an ipsy ormed? 2 No one)	23d. Date of delive Month See contribute to the Month of	Approximate Interval Between Onset and Death Onset and Death Onset and Death Death Onset and Death Death Onset and Death Death Onset and Death
his certificate has been signed by the attending physician and in second continuation of the beautificated for use as the burial-transit and a large a	To Be Completed by Physician/Medical	23a. Part1. Enter the disease, or compshock, or heart failure. List only of large states of condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a consequence cause) Due to (or as a consequence	in Do not enter the Land Death Syndiquence of): Juence of	mode of dying, such as cardinated by the suc	23e. Did 1 24a. Wa. auto	tobacco u Yes 25 san ipsy ormed? 2□No one)	23d. Date of delive Month See contribute to the Month of	Approximate Interval Between Onset and Death Onset and Death Onset and Death Death Onset and Death Death Onset and Death Death Onset and Death
Director: After this certificate has been signed by the attending physician and up by by by by by the funeral director, page 2 should be detached for use as the burial-transit and land in by the funeral director, page 2 should be detached for use as the burial-transit.	To Be Completed by Physician/Medical	23a. Part1. Enter the disease, or compshock, or heart failure. List only of shock, or heart failure. Sequentially list conditions, if any leading to immediate cause. Enter Underfying Cause (Disease or injury that intitated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a consequence cause) Due to (or as a consequence	th. Do not enter the Death Syndiquence of): quence of):	mode of dying, such as cardial mode of dying, such as cardial mode of dying, such as cardial mode of dying, such as cardial mode of dying cause given in Part I. 26. Place of D 26. Place of D 26. Place of D 26. Place of D 27. DOA 28. Injury at Work? 1 Yes 2 No	23e. Did 1 24a. Waxauta perf 1 Yes 28d. Describe 28f. Location	tobacco u Yes 28 s an ipsy ormed? 2 No one) idence 6 how injury	23d. Date of delive Month se contribute to the Month of	Approximate Interval Between Onset and Death Onset and Death Onset and Death D
is certificate has been signed by the attending physician and upposite director, page 2 should be detached for use as the burial-transit up to use as the burial-transit up to use use the burial-transit up to use use the burial-transit up to use use the burial-transit up to use use use up to use use use use use use use use use use	o Be Completed by Physician/Medical	23a. Part1. Enter the disease, or compshock, or heart failure. List only of shock, or heart failure. Sequentially list conditions, if any leading to immediate cause. Enter Underfying Cause (Disease or injury that intitated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II, Other significant conditions of examiner? 1 Xeyes 2 No 25. Was case referred to medical examiner? 1 Xeyes 2 No 27. Manner of Death Tending investigation	Due to (or as a consequence) Due to (or as a consequence)	ancy al death 3 Ectop death 5 Other Sulting in the underlying in t	mode of dying, such as cardial mode of dying, such as cardial mode of dying, such as cardial mode of the c	23e. Did 1 24a. Was auto perfit 1 Yes eath (Check only Home 5 28d. Describe 28f. Location City or To	tobacco u Yes 25 s an psy ormed? 2 No one) idence (how injur (Street an. wn, State)	23d. Date of delive Month Se contribute to the Month No 3 pro 24b. Were authority to contribute to the Month of the Mon	Approximate Interval Between Onset and Death Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Onset and Death Death Onset and Death

State Registrar

2ABILLITH

31. Date filed (Month, Day, Year)

JAN 1 5 20 32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Physician STANLEY **GOLDBERG** JANUARY 11,2004 10:15 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner 6412 HICKORY LANE **ELDERSBURG** CARROLL 8. Date of Birth (Month, Day, Year) FEB.19,1929 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 74 MD 220-20-0423 Director Usual Residence of Decedent death with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "natural", or items 23e or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director CARROLL **ELDERSBURG** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6412 HICKORY LANE 21784 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If tiem 27 is marked other then "natural", or flet important: If tiem 27 is marked other then "natural", or flet any injury or other traumatic event, the Medical Examines and. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: WHITE þ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWNER RETAIL 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be SAMUEL GOLDBERG CECELIA HOROWITZ ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 HIGH SIDE COURT - OWINGS MILLS, MD 21117 DAVID GOLDBERG / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BETH TFILOH CEMETERY 1/14/2004 WOODLAWN, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses SOL LEVINSON & BROS., INC. Edward - Kum 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician arcinoma mon disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially let conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): physician and s the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending | IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown signed by d Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy certificate 1 Yes 2 No the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Other: 4 Nursing Home 5 K esidence 6 Other (Specify) Hospital: ၉ 1 Yes 2 No 3 DOA 1 Inpatient 2 ER/Outpatient After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L Conflying Physician: To the best of my knowledge, Jeath occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartillar Medical (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) of death (Item 23a) (Type, Print) State Registrar

			1 - For Stata Registrar	State of M	laryland	d / Depa	artmen rtificate	t of H	ealth a	and M		Reg. No.	004	00.	749
	Physici		1. Decedent's Name (First, Middle, L HELEN	ast) GRA	Y						2. Date of Dea		Year 2004	3. Time of 1	
	/Medio Examir		4a. Facility Name (If not institution, go		•		BALT	1000				4c. Cou	inty of Death	RĒ	
	Funeral Director		220-05-9229		nge (In yrs. la 82	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birt (Month, Day OCT 2	h , Year) 921	9. Birthp Cour Mar	lace (State or try) y l and	Foreign
	e Maryland e-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Anne Art	ındel		n Bur							1	0d. Inside City 1 ☐ Yes	•
	h with th	al Directo	10e. Street and Number 7711 Norfolk	Road			10f. Zip	code 1060				10g. Citizen USA	of What Cour	itry?	
920	72 hours after death with the Maryland haturel, or Items 23e or 28e-f show dical Examiner must be myffred at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1 Yes 2 2 If Yes, Give Year or Dates	? No		Was Deced f Yes, spec 1 Yes 2				city Yes or No- Rican, etc.)		Race - Americ Black, White, cify: Wh		
121	within ene. then	Completed by	15. Decedent's I (Specify only highest g Elementary/Secondary (0-12)	Education rade completed) College (1-4o	5+)	life. I	ient's Usua kind of wor DO NOT us Waitr	k done d e retired	lurina mos	st of workin	ng		Business/Ind		
land 2	ild be filed fental Hygid rked other itc event, il	To Be C	17. Father's Name (First, Middle, Las	oit) M	k	(ellih				ers Name Grac	(First, Middle,	Maiden Sun			
Mary	12 shou h and M 7 Is mai traumai		19a. Informant's Name/Relationship Nettie Seekford	(Type, Print) Sister			•				a Buraj	r, City or To	vn, State, Zip		
more,	of H of H if ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 1 ☐ Donation, 5 ☐ Other (Spec		Ce	ace of Dispo emetery, crem	sition (Narr natory or of	ne or ther place	9)	D	ate	20c. Locatio	m-City or To		
Balti	permit. Pag Department Importent: any injury o		21. Signatur of Fun ral Service Lid	5 /		22	. Name and	Addres	s of Facilit Dunta	y Sta in Ro	allings oad Pas	Funer adena,	al Horr	e P.A.	
	Trysician		23a. Part1. Enter the disease, or con shock, or heart failure. List onl Immediate Cause (Final disease or condition	mplications that cause y one cause on each SEPT		SHO	er the mode	of dying	, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Betw Onset and Do	reen
	/Medical Examiner		resulting in death) Sequentially list conditions,	b		ence of):	i F	41L C	IRE					5	
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the buriat-transit	dicai Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	s a consequ s a consequ										
P.O. Box 6	that the death certific led by the attending pl detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal	death 3 [Ectopic pre						Date of delive Month	,	ear .
ds, P.	juires that n signed by	ò	Part II. Other significant conditions	contributing to death	but not resu	ilting in the ur	nderlying ca	iuse give アS圧	n in Part I.				ontribute to th		
		Completed	COLON CLOSTRIDI,			= 0	OLIT	15			24a. Was a autop: perfor 1 Yes	med?	b. Were autor prior to con death? 1 \(\text{Yes}		vailable use of
Vita	Physicien: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ient 2∏E	ER/Outpatien	t 3 🗆 DO	A Othe			(Check only or ne 5 ☐ Resid		Other (Specific	1	
ion of	and Affer und	ertification; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of In (Month, D	iury	28b. Time of Injury		3c. injury Work	at ? ′es 2 □	2	8d. Describe h			/	
Divis	in Diffe	Certific	3 Suicide 6 Could not 4 Homicide determine	d 286. Place of I	njury - At hor atc. <i>(Specify)</i>	me, farm, stro)	eet, factory	, office		2	8f. Location (S City or Tow		mber or Rurai	Route Numbe	e <i>r</i> ,
W	FL T	edical	(Check only 2 ☐ Medical Exa	Physician: To the besiminer: On the basis and manners	of examinati	vledge, death ion and/or inv	estigation,	in my op	inion, dea	d place, a th occurre	d at the time, d	ate and plac	e, and due to	the cause(s)	
	To the To the complete	Σ	29b. Signature and title of certifier	MED	ICAL	DOC 70	PR	PI	number 7-7-5	35		TANUAR	ned (Month, L マイ, O '	7,200	04
	V		30. Name and address of person who HARIS AL 31. Date filed (Month, Day, Year)	completed cause of	death (Item	23a) (Type,	Print)	ER	Sr	BA	ZTIMOO,	RE_j	MD -	2/22	5-
	Sta Registr	ite ar	31. Date filed (Month, Day, Year)	1 5 2004 Regis	trar's Signati	ure de	Line	()							

	_		State of Maryland	l / Depart		ealth and N	lental Hygie	ene 2001	00750
		Registrar		Certi	iicale oi L	Jeani	2. Date of Death	. No 0 0 1	3. Time of Death
Physicia	an .	Decedent's Name (First, Middle, Last)					Month	Day Year	
/Medic	al	Loretta Young 4a. Facility Name (If not institution, give str	Hopping reet and number)	4	b. City, Town, or	Location of Death	January 1	4c. County of Deat	2:25 p ^m
		Crofton Convalesce	nt & Rehab. Co	enter	Croft			Anne Arur	
Funeral		Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	eer) 9. Birt	hplace (State or Foreign untry)
Director		577-05-0219	M 2 X □F 89	Yrs.			May 14, 1		shington, DC
p.		Usual Residence of Decedent	10c City	Town or Local	tion				10d. Inside City Limits
irylar show	_	10a. State 10b. County	Toc. City,	TOWIT OF LOCA	lion				1 ☐ Yes 2 ☐XNo
e Ma	5	Maryland Anne Arun	de1	Oden					
with the Maryland a or 28a-f ehow	Director	10e. Štreet and Number			10f. Zip Code		10g	, Citizen of What Co	untry?
th wi		705 Orchard Overl	ook #102		211			Jnited Sta	
dea	Funerai	11. Marital Status	Was Decedent Ever in U.S Armed Forces?	5. 13. Wa	is Decedent of Hi es, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
or It	F	1 Never Married 2 Married	1 ☐ Yes 2 TNo If Yes, Give	10	Yes 25√2 No	Specify:		Specify:	White
72 hours after death with the Maryland 72 hours after death with the Maryland natural; or Items 23s or 28s-1 show area Examiner must be notified	d by	3 Widowed 4 Divorced	Year or Dates:		71		1		
	Completed	15. Decedent's Education (Specify only highest grade	ation completed)	(Give kir	nt's Usual Occupa nd of work done o	furing most of wor	king 16	b. Kind of Business/	Industry
ithin	idu	Elementary/Secondary (0-12)	College (1-4or 5+)	irre. DC	NOT use retired	,			
filed within Hygiene. other then		12th		Ноп	nemaker	19 Mother's Nam	ne (First, Middle, Ma	Own Hon	ne
be fited withintal Hygiene. Id other then	Be	17. Father's Name (First, Middle, Last)							
should nd Men i marke umatic	၉	John Creswell	Young			Eva		ılkner	
		19a. Informant's Name/Relationship (Typ		_				City or Town, Stete, 2	_
and and and malth malth		Kenneth H. Hopping		_	h Court		n Falls, (
Titer of H		20a. Method of Disposition 14∑ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	ace of Disposit Imetery, crema	ion (Name of tory or other plac			c. Location - City or	Iown, State
Pag Pag nent ant: h		* 4 □ Donation 5 □ Other (Specify)		Lincol	n Cemete	ery 1/1	7/2004 B	ladensbur;	g, Maryland
permit. Pages 1 and 2 Department of Health 2 Importent: If item 27 is any injury or other tre		21. Signatore of Funeral Service License	70		Name and Addres		Home & Cr	ematory,	РΛ
88558	6.0	1 Marita X		095/ 14	11 Annaj	polis Roa	id Odento	on, Maryla	ind 21113
		23a. Part . Enter the disease, or complice shock or heart failure. List only one	ations that caused the death	. Do not enter	the mode of dyin	g, such as cardiac	or respiratory arrest	t,	Approximate Interval Between
Physician		Immediate Cause (Final	Carona	114/			is foir		Onset and Death
/Medical		disease or condition resulting in death)	Due to (or as a consequ	ence off.	47.01	1 2	13 (007		7 (0003,
Examiner			Historite	nsivo	e Cour	olic Vil	sculon	Distein	Home
	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ						
uted s ansit	ᇤ	cause. Enter Underlying Cause (Disease or injury that initiated events	Can di	OC	CUN	7+6	mia		years
ou, be executed ician and burial-transit	Examiner	resulting in death) Last	Due to (or as a consequ	ence of):		1			
	le c								
The faw requires that the death certificate are has been signed by the attending physicage 2 should be detached for use as the		<u>.</u>							
centi ding	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant 23	ic. If yes, outcome of pregnar					23d. Date of del	ivery
attence for us	ciar	in the past 12 months?	1 Live birth 2 Fetal 4 Pregnant at time of de		ctopic pregnancy Other (specify)			Month	Day Year
the d	iysi	1 ☐ Yes 2 ☐XNo 9 ☐ Unknown	9□ Unknown						
that the bed by deta		Part II. Other significant conditions con	tributing to death but not resu	ilting in the und	erlying cause givi	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
w requires been sign should be	d by	Pankin-Sov	3 Discon	~			1 ☐ Yes	2 No 3 ₽	obably 4 Unknown
red red shoul	Completed			,			24a. Was an	24h Word 24	utopsy findings available
has I	igh						autopsy performe	prior to	completion of cause of
The The pag	Ö							No 1 ☐ Yes	2 □ No
VICAL ician: 1 certifica ector, p	Be	25. Was case referred to medical examiner?			Oth		th (Check only one)		
Physic ruthis or	은	10193 23 140		ER/Outpatient	3□ DOA Oth	4 Nursing H		ce 6 ☐Other (Spe	cify)
ng P ng P shert snera	ë.	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injun World		28d. Describe how	injury occurred	
VISION Attending or death. ector: Atte by the fune	Certification:	2 Accident investigation				Yes 2 □ No			
r Att	Ę	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, larm, stree	et, factory, office	i i	28f. Location (Stre City or Town,	et and Number or Ri State)	ural Route Number,
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: Atter this certificate has completely filled in by the funeral director, page 2	Çe								
lospi hou uner	edical		ician: To the best of my knower: On the basis of examinat						
he H in 24 ihe F iplete		one)	and manner stated.						
To t To t	Σ	29b. Signature and title of certifier		7 (4 8	29c. Licens	e number	C 290	d. Date signed (Mont	n, Day, Year) ~ L_1
10		1. Karking	1 allo	COLV	リレレ	1201	07	1/13/0	
()		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, P	rint)		MICH STATE OF THE		
		Rakesh Aurora, M			ox Lane	Bowie,	Maryland	20715 Su	ite 222
Sta	ate	31. Date filed (Month, Day, Year)	5 2018 (Registrars Gigna	ture #	Speck	y			

	State of Maryland / De	epartment of Health and Mental F Certificate of Death	_
Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) 2. 1. 2. 1. 2. 1. 2. 1. 4a. Facility Name (If not institution, give street and number)	2. Date of Month 4b. City, Town or Location of Death	Death Day Year O 9 4c. County of Death
Funeral Director	10104 Scouts Circle 5. Social Security Number 5. Total Security Number 5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birtho		Birth Day, Year) 9. Birthplace (State or Foreign Country) 1, 1913 Washington, D.(
r 28a-f show	10a. State 10b. County 10c. City, Town of MD Frederick Walkers		10d. Inside City Limits 1 ☐ Yes �∏ No
ter death with	1 Never Married 2 Married 1 Yes 2 No	10f. Zip Code 21793 13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:	No- 10g. Citizen of What Country? U.S.A. No- 14. Race - American Indian, Black, White, etc. Specify: White
"natura dical	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	ecedent's Usual Occupation Sive kind of work done during most of working fe. DO NOT use retired) HOMEMAKEY	16b. Kind of Business/Industry Own Home
w dab	17. Father's Name (First, Middle, Last) John Hoover Klein	18. Mother's Name (First, Mid Amelia Schwig	dle, Maiden Sumame) gert
na tea	Irene Cecelia Lawson / daughter 723 20a. Method of Disposition 20b. Place of Disposition competery,	failing Address (Street and Number or Rural Route Num 7 Talbot Run Road Mt. Ai isposition (Name of crematory of other place) is Church Cem. 1/13/2004	ry, MD 21771 20c. Location - City or Town, State Clarksville, MD
permit. Pages 'Department of Pimportant: If ite any injury or of once.	21. Signature of Funeral Service Licensee /M00770		el, Maryland 20707
tificate be executed as the burial-transit as the burial-transit edical Examiner	d		Interval Between Onset and Death
requires that the death certificate be en been signed by the attending physician should be detached for use as the buria	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of delivery Month Day Year
Hospited or Attending Physician: The law requires that the death certificat 4 hours after death. 4. Hours after death. Funeral Director: After this certificate has been signed by the attending phytely filled in by the funeral director, page 2 should be detached for use as the lical Certification: To Be Completed by Physiclan/Medilical	Part II. Other signmeant conditions contributing to death but not resulting in the	1 24a. W	utopsy prior to completion of cause of death?
To the Hospitel or Attending Physician: The law requires that the dwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached Medical Certification: To Be Completed by Physi	25. Was case referred to medical examiner? 1 Yes 2 StNo Hospital: 1 Inpatient 2 EP/Outpo	ne of 28c. Injury at 28d. Descri	
the Hospitel or Attending Pithin 24 hours attendently in the Euneral Director: Alter the mapletely filled in by the tuneral Medical Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)		in (Street and Number or Rural Route Number, Town, State)
To the Hospitel within 24 hours a To the Funeral I completely filled Medical Ce	29a. Certifier (Check only one) 1 ★ Certifying Physician: To the best of my knowledge, c 2 ★ Medical Examiner: On the basis of examination and/c and manner stated.	death occurred at the time, date and place, and due to to reinvestigation, in my opinion, death occurred at the time. 29c. License number	the cause(s) and manner as stated. ne, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)
1	Michael Levner M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type 1) (Type 2) (D 41619	January 10, 2004
State Registrar	Michael A. Lerner, M.D. 63 Thomas 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Johnson Drive Suite E	Frederick, MD 21702

		For State Registrar	State of Marylar	•	artmer rtificat			Mental H	Reg. No	200	14 0 (0752 ne of Death
Physicia /Medica Examine	al .	Decedent's Name (First, Middle, Las Wilbert Wilbert As. Facility Name (If not institution, give		Harp		Town, or	Location of De	Month 1	9 2	Y Y E 2004 County of E	4:15	4.4
Funeral Director		5435 Radecke Ave. 5. Social Security Number 6. Sr 214-38-2322		. last birthday) Yrs.	If Unde Months	r 1 Year	lf Under 24 F Hours M			NA 9.	Birthplace (Sta	ate or Foreign
a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Md. NA	10c. C	ity, Town or Lo							10d. Insid	le City Limits Yes 2 No
deeth v	Funeral Director	10e. Street and Number 5435 Radecke Ave. 11. Marital Status 1 □ Never Married Ave. Married	t2. Was Decedent Ever in t Armed Forces? 1 ☐ Yes = 2 ☑ No If Yes, Give ²		21 Was Dece	city Cubai	spanic Origin? n, Mexican, Pu	(Specify Yes or Perto Rican, etc.)	J	Black, \	American Indian White, etc. Black	n,
within 72 hours after siene. Then "natural", or lite	Completed by	3 Widowed 4 Divorced 15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	Year or Dates:	16a. Dece (Give life.	dent's Usu	al Occupa ork done d se retired,	ition luring most of t	working	16b. K		ess/Industry	
y carrier ould be file Mental H varked oth vatic even	To Be C	6th grade 17. Father's Name (First, Middle, Last) Earl 19a. Informant's Name/Relationship (i	Slaught	ter			18. Mother's Ro	Name (First, Midd DSA Rural Route Num	Mae		Harper	
nd 2 lith a 27 Is		Annie Taylor Har	per Wife	543	S5 Rac	lecke		Baltimore	e, Md	. 212	206	
permit. Pages 1 and Department of Heali Importent: If item 2 any injury or other page.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	Place of Dispo cemetery, cre Mt. Zic	matory or	other place	. 1	Date 16-04	1		y or Town, State	9
permit. Departm Importe any inju		21. Signature of Funeral Service Licer		2:	2. Name a	nd Addres	s of Facility	Balt 1101 I		e, Md.		2
Physician /Medical		23 Part1. Enter the disease, or comshock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a conse	ath. Do not en	ter the mo	de of dying	g, such as card	fiac or respiratory	arrest,		Approxi Interval Onset a	Between and Death
ysicia e bur	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conse		li	12~	grat	t r	eje	ction	n 8 m	mh5
The law requires that the death certificate are been signed by the attending phy: page 2 should be detached for use as the	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fel 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	□Ectopic p					23d. Date o Month		Year
w requires that been signed be should be deta		Part II. Other significant conditions of	ontributing to death but not re			cause give	en in Part I.			_	ite to the cause	
	Completed				-			pe. 1 ☐ Yes	opsy formed? 2 No	prio	re autopsy finding to completion th? Yes 27 No	ngs available of cause of
ding Phys After this funeral di	tlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Yeer)	ER/Outpatie 28b. Time o Injury		28c. Injury World	er: 4 □ Nursin	g Home 5 Ae 28d. Describ	sidence	-	(Specify)	
To the Nospitel or Attending Phy within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral or	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	cify)				City or 1	own, State)	or Rural Route I	Vumber,
To the Hospite within 24 hours To the Funeral completely filled	Medical	29a. Certifier (Check only one) i Certifying Ph 2 Medical Exam	nysicien: To the best of my kr niner: On the basis of examin and manner stated.	nowledge, dear nation and/or in	th occurred nvestigation	at the time n, in my op	ne, date and pl	ace, and due to th courred at the tim	e cause(s e, date and	and manne d place, and	er as stated. I due to the cau	se(s)
To the vithing of the the comp	Me	29b. Signature and title of certifier 30. Name and address of person who	completed source of death (the	8m 23a\ /Tuno		13	885	8	29d. Da	te signed (A	Month, Day, Yea	r) T
Star Registra		Jacqueline 31. Date filed (Month, Day, Year)		MO	An	e R e						

	1	For State Registrar	St	ate of M	arylan		artment rtificate			and M	lental Hy	ygien Reg. N	- 61	104	00753	The Part I have
Physician		1. Decedent's Neme (First, Middle,	Last)								2. Date of D Month		ay	Yeer	3. Time of Death	
/Medica		Katherine		rgaret		Han:	T				Januar	-		04	10:27 pM	_
Examine	1	la. Facility Name (If not institution,)		4b. City,	Town, or	Location o	of Death			c. County			
ă.		Riverview Care 5. Social Security Number	Cente		ne (In vrs	last birthday)	Esse:		If Under	24 Hrs.	8 Date of B		Balti			
Funeral Director		212-07-8345 Usual Residence of Decedent	1 M		84	Yrs.	Months	Days	Hours	Min.	8. Date of B (Month, D 8/2/1	919	r)		place (State or Foreign intry) nsylvania	
A w	- 1-	10a. State 10b. County			10c. Cit	y, Town or Lo	cation								10d. Inside City Limits	-
rai, or itama 23a or 28a-f ehow Evanifiet maal be indiffed at The Firmeral Director	5	Maryland Balti	more		Ess	ex									1 ☐ Yes 2X No	
andilla	5	10e. Street and Number			1		10f. Zip	Code				10g. C	itizen of \	What Cou	intry?	~
ordina 23a or 28a-1 e	2	142 Riverside R					21.	221				U.	S. A	١.		
9	2	11. Marital Status	12. W	/as Decedent med Forces ☐ Yes 2 ☐	Ever in U	.S. 13.	Was Deced	ent of Hi	spanic Orig	gin? (Spe i, Puerto	cify Yes or N Rican, etc.)	0-		e - Ameri ck, White,	ican Indian, , etc.	
i i		1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	lf lf	Yes, Give	No		1□Yes 2	2 (XNo	Specify:				Specify	y:		
Completed by	2	15. Decedent's	1	ear or Dates:		16a Dece	dent's Usua	I Occupa	ation			16b	Kind of B	,,,,,	ite	
lotor	100	(Specify only highest	grade con	npleted)		(Give	kind of wor DO NOT us	rk done d e retired	during most	t of worki	ng	100.	KIIIG OI DI	usin a ss/ii	loustry	
ag ag	5	Elementary/Secondary (0-12)	C	ollege (1-4or	5+)	Homem						Oz	vn Ho	me		
event, #		17. Father's Name (First, Middle, Li	est)			HOME	anc _L		18. Mothe	r's Name	(First, Middl					-
To B	0	Louis Toth							Kat	heri	ne –	Tas	sner			
aumatic eve		19a. Informant's Name/Relationshi	р (Туре, Р	rint)		19b. Mailii	ng Address	(Street a	and Numbe	r or Aura	I Route Num	ber, City	or Town,	State, Zip	p Code)	1
2 2	Ц	Paul Anthony Ha	nnon	(Husba		142 R			Road	Ess	ex, Ma	ryla	and 2	1221		
no be	1	20a. Method of Disposition 1 XBurial 2 □ Cremation	. □ Bamos	al from State	1 -	Place of Dispo cemetery, crei	sition (Nam natory or of	ne of ther place	θ)		ate / 1 F	20c.	Location -	City or To	own, Stete	
ortant: if injury or ie.		`4 □Donation 5 □Other (Spe		vai irum State	1	dens o	f Fai	th C	em.	26	15 04	Ba	altin	ore.	Maryland	
Important: If any injury o once.		21. Signature of Funeral Service Li	censee			22 R	Name and	Addres	s of Facility	y pera 1	Home			-	•	Ī
E # 9		Michael C.	200	fear .	5	17	407 0	Id E	aster	n Av	Home enue	ESS	ex, M	aryl	and 21221	-
		23a. Part1. Enter the disease, or shock, or heart failure. List o	implicationly one ca	ns that cause use on each l	d the deat ine.	h. Do not en	er the mode	of dying	g, such as	cardiac c	r respiratory	arrest,			Approximate Interval Between Onset and Death	
hysician and the burial-transit and the burial-transit	LYa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or as												
ed by the attending ph detached for use as the	Пузісіатимец	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	1 4	yes, outcome Live birth Pregnant a	2 Feta	I death 3	Ectopic pre						23d. Dai Mo	te of delive	ery Day Year	
be det		Part II. Other significant condition	s contribu	ting to death I	but not res	ulting in the u	nderlying ca	ause give	en in Part I.		23e. Did	tobacco	use cont	ribute to t	the cause of death?	
should b		densutia									1 🗆	Yes	2 🗆 No	3 🗆 Prot	babiy 4 🕍 nknown	
2 0 0	ב ב	osteoperosis									24a. Wa	s an	24b. \	Were auto	opsy findings available ompletion of cause of	-
ector, page	5	Chronicossky com	_Pur	mary	Dice	n						ormed?	(death?	2□ No	
director,	U	25. Was case referred to medical examiner?				-		_		of Death	(Check only	one)				-
a d	2	1 ☐ Yes 2\tilde{\tilie}\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde{\tilde	Hospit	I 🗀 inpati		ER/Outpatier			4K Nu	7.5	me 5□Res	_	_		fy)	
uner L	5	27. Manner of Death 1X Natural 5 ☐ Pending		la. Date of Inju (Month, Da	ury ay Year)	28b. Time o Injury		Bc. Injury Work			28d. Describe	how in	ury occurr	ed		
y the fu	Sal	2 Accident investigation inves	t ho	a Olasa of In	diama At h		M		Yes 2□1		201 Location	/Cara a a	and Advanta		-/ Courts Museum	-
ef Director: After		4 Homicide determin	ed 25	le. Place of In building, e	tc. (Specil	y)	eet, lactory	, office		4	City or To	wn, Sta	te)	er or Hura	al Route Number,	
completely filled in by the f	nical C	29a. Certifier (Check only one) Certifying Certifying Certifying Certifying	xaminer: (n: To the best On the basis of	of examina	owledge, deat ation and/or in	h occurred a vestigation,	at the tim	ne, date and pinion, deat	d place, a	and due to the	cause(s) and ma	inner as s and due to	stated. o the cause(s)	-
o the		29b. Signature and title of certifier					29c	License	number			29d. D	ate signed	d (Month,	Day, Year)	+
0		> purmare	Kea	is and	8			196	67			T		. 12	2004	
		30. Name and address of person w	ho comple	ted cause of	death (Iter	n 23a) (Type,		130	0 /			_uai	ıuafy	12,	2004	-
ノ		Dr. Michael Sch	warts	z M.D.	_731	0_Ritc	hie H	i ahw	av Si	uite	508	Glen	Burr	nie.	MD 21061	
State		31. Date filed (Month, Day, Year)		32. Regist	rar Signa	ature										
Registra		JAN	152	004	Charles	- 15.	600	ACR. S								-

		1	For State Registrar		State of M	/laryland	-	rtment of I		d Mental Hy	giene Reg. No. 2	004	00754
	Physicia		1. Decedent's Name (i							2. Date of De Month	Day	Year	3. Time of Death (12:55 AM
	/Medic Examin		4a. Facility Name (If no		mes	7)		4b. City, Town, o	or Location of D	Januar eath	· ·	nty of Death	
	Funeral Director		5. Social Security Num	nber 6. Sex	7. A	Age (In yrs. Ias	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 I Hours N	Hrs. 8. Date of Bi (Month, D 12/11/	ay, Year)	9. Birth	place (State or Foreign ntry)
	deeth with the Maryland ms 23a or 28a-f show frmust be notified at		Usual Residence of De 10a. State 1 MD	ecedent Ob. County Baltimo:			fown or Loc						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	or 28a-	Director	10e. Street and Numb	per			acons	10f. Zip Code			10g. Citizen o		ntry?
36	s 1 and 2 should be filed within 72 hours after deeth with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at	by Funeral	717 Maide: 11. Marital Status 1 □ Never Married 3 ☑ Widowed 4	d 2 Married	Lane 12. Was Deceder Armed Force: 1 Yes 2 If Yes, Give Year or Dates	s? ₹No		las Decedent of I Yes, specify Cub		? (Specify Yes or Nuerto Rican, etc.)	0- 14. R B	USA ace - Ameri lack, White, cify:	
Maryland 21215-0036	within 72 hour ene. than *natural	Completed b	15	5. Decedent's Edu only highest grad	cation		(Give k lite. D	ent's Usual Occu ind of work done O NOT use retire	pation during most of d)	working	16b. Kind of		ndustry
nd 21	be filed wi tal Hygien d other th event, the	Be Con	12 17. Father's Name (Fig.	irst, Middle, Last)			Sec	retary	18. Mother's	Name (First, Middle			hants Assn.
faryla	2 should be filed within and Mental Hygiene. Is marked other than raumatic event, the Mi	P _C	George C. 19a. Informant's Nam	ne/Relationship (Ty					and Number o	E. Schu	oer, City or Tow		
lore, N	ges 1 and it of Health if Item 27 or other to	ŀ		sition Cremation 3 DF		te cen	e of Dispos netery, crem	Walnutwo ition (Name of atory or other pla	ice)	Cockeysv	20c. Locatio	n - City or T	own, State
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other trae	I	*4 □ Donation 5		90	Loud	W1	Name and Addre	ess of Facility	/17/2004 ome Of Ca ve. Balt	tonsvi1	le, I	nc.
	Physician		23a. Part1. Enter the shock, othean filmmediate Cause (Findisease or condition resulting in death)		Strol	ce	Do not ente						Approximate Interval Between Onset and Death
W.	Medical Examiner thysician and the purial-transit	Examiner	Sequentially list cond if any, leading to imm cause. Enter Underly Cause (Listass or Intat initiated events resulting in death) La:	litions, rediate ring juny st	Due to (or a	as a conseque as a conseque as a conseque	nce of):						<i>y</i>
் O. Box 68760	ath certificate ttending phy or use as the	by Physician/Medical B	IF FEMALE: 23b. Was decedent p in the past 12 m 1 Tyes 2 T	nonths?		2 Fetal d at time of dea	eath 3	Ectopic pregnand Other (specify)	÷у			Date of deliv	rery Day Year
م.	uires that the de signed by the a Id be detached f		9 Unknown Part II. Other signification	ant conditions co.	ntributing to death	n but not result	ing in the un	derlying cause gi	ven in Part I.		tobacco use co		the cause of death?
Reco		Completed								24a. Wha auto peri 1 🗆 Yes	s an 24l opsy ormed? 2 X No	b. Were auto prior to co death? 1 \(\sum \text{Yes}	opsy findings available ompletion of cause of
HaymesDivision of Vital	hysicien: this certific al director,	To Be	25. Was case referred examiner? 1 ☐ Yes 2 No. 27. Manner of Death	0	Hospital: 1 X Inpa 28a. Date of In (Month, I		VOutpatient	3□ DOA Ot	her: 4 🗆 Nursir	Death (Check only ng Home 5 Res 28d. Describe		- ' '	fy)
Ha		ertification:	1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	5 Pending investigation 6 Could not be determined	28e. Place of		Injury e, farm, stre]Yes 2□No		(Street and Num own, State)	mber or Rur	al Route Number,
	Hospitel 24 hours Funerel tely filled	edical Ce	29a. Certifier 1. (Check only 2 one)	Certifying Phy	sician: To the be ner: On the basis and manner	s of examinatio	edge, death n and/or inv	occurred at the t estigation, in my	ime, date and p opinion, death o	lace, and due to the	cause(s) and , date and plac	manner as : e, and due !	stated. to the cause(s)
	To the within 2 To the comple	Mec	^	e of certifier		touse a	2-1		se number 5623		29d. Date sig		Day, Year)
	18		30. Name and address	.1 2.	ompleted cause of	of death (Item 2	Ces (Type, 1 aton	Print)		M. M.D.	2190		, , , , , ,
	Sta Regist	ate rar	31. Date filed (Month)	11.00		istrar's Signatu		è			7.00		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygienes of Archive Indexes and Mental Hygien

				State of IV	iaryianu /	•	ate of Death		eg. No.	14 00755
	Dhysisi		1. Decedent's Name (First, Middle,	Last)				2. Date of Deat	th	3. Time of Death
	Physici /Medio		GEORGE	Horn			(I) (C) T	JANUAr Location of Death	y 12 2	004 9 DM
	Examir	er	4a. Facility Name (Whot institution, of Mill ENNIUM H	Falth 'E	Jehah 1	Tenler	Ellico LL	C. L.I	4c. County of	Death
	Funeral			Sev 7 A	ge (In yrs. last b	oirthday) If Unc Month	ler 1 Year If Under 24 Hrs s Days Hours Min	8. Date of Birth	Voar) 9	Birthplace (State or Foreign Country)
0	Director		219-01-5267	ùXXM 2□F	98	Yrs.	s Days Hours Min	Month, Day,	,1905 I	Pennsylvania
	land Dw		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Location				10d. Inside City Limits
	ath with the Marylan 23a or 28e-f show wet be notified all	tor	Maryland Howa	rd	E	llicott	City			1 ☐ Yes 2XXXVo
	or 28c	Funeral Director	10e. Street and Number	-			Zip Code	1	0g. Citizen of Wha	at Country?
	ath w	ral	3000 N. Ridge R				21042		U.S.A.	
	Items Iner	une	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Armed Forces 1 ☐ Yes 2 🖸	t Ever in U,S. ?	13. Was Dec	edent of Hispanic Origin? (Specify Cuban, Mexican, Puer	Specify Yes or No- nto Rican, etc.)		American Indian, White, etc.
21215-0020	n 72 hours after death with the Maryland "netural", or Items 23a or 28e-f show sdical Exprénet must be notified at	by	34 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	140	1 ☐ Yes	2. No Specify:		Specify:	White
5-0	72 ho	To Be Completed	15. Decedent's (Specify only highest t	Education grade completed)	16	a. Decedent's Us (Give kind of v	ual Occupation work done during most of wo use retired)	orking	16b. Kind of Busin	ness/industry
121	within ene. than I	ш	Elementary/Secondary (0-12)	College (1-4or	5+)	Puppete			Enterta	ninment
d 2	filed Hygie other ent,	ပိ	17. Father's Name (First, Middle, La	st)		ruppete		me (First, Middle, M		
ılan	ald be fental rked c	OB	Samuel Horn				Sarah	Atherholt	:	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after dea beatment of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Items any injury or other treumatic event, the Medical Examinar monce.		19a. Informant's Name/Relationship Susanne Krauch	(Type, Print) (Daughter			ss (Street and Number or A Cham Road E11			
Baltimore,	es 1 a of Hei		20a. Method of Disposition 1 🖾 Burial 2 □ Cremation 3	□ Bomouel from State	20b. Place cemet	of Disposition (Nery, crematory of	ame of other place)	Date	20c. Location - Cit	ty or Town, State
ti m	Pages ment of ant: If ite		4 □ Donation 5 □ Other (Spe				k Cemetery	1-16-04	Woodlawn	, Maryland
Bal	permit. Departr Importa any Inji		21. Signature of Funeral Service Lic	ensee . H.Q.		Witzke	^{and Address of Facility} e Funeral Hom Edmondson Ave			
			23a. Part1. Enter the disease, or co shock, or beart failure. List on	mplications that cause ly one cause on each l	d the death. Do					Approximate Interval Between
and the same	Physician /Medical		Immediate Cause (Final	06		1 cha	Hyperte	nemen 1	Discar	Onset and Death
	Examiner		disease or condition resulting in death)	a	Due to forms	n Sarvy	eng july	rang 1	rpeo	
	T #	ner	45	· Mu	Iti W	Vonc 1	Leno	nha		
	end -trans	хаш	Sequentially list conditions,	D	Due to (or as a	consequence o): // £	0.10	1-	
68760,	sician burie	aiE	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c	Sente	al	Hyperol	npio	,	
x 687	The law requires that the death certificate be executed ate has been signed by the ettending physician end page 2 should be detached for use es the buriel-transit	Physician/Medical Examiner	resulting in death) Last		Due to (or as a	consequence of): /			
Вох	r requires that the death cer been signed by the ettendin should be detached for use	clan	Dark II. Other simplificant and distance				Section 1	ant Dista	2010	
P.O.	t the d by the	hysi	Part II. Other aignificant conditions	contributing to death t	out not resulting	in the underlying	cause given in Part I.			ibute to the cause of death? ☐ Probably 4☐ Unknown
S, F	es tha gned be del	by P								
Records,	requir een s hould	Completed						24a. Was ar perform		24b. Were autopsy findings available prior to completion of cause
၁မင	e law has b je 2 s	ם								of deeth?
Vital	n: Th	ပိ	25. Was case referrent to medical				26 Place of De	1 ☐ Ye		1 ☐ Yes 2 ☐ 1\0
Š	ysicie s cert direct	To B	examiner?	Hospital: 1 ☐ Inpati	ent 2 ER/C	Outpatient 3 1	Other:	ath <i>(Check only on</i> Home 5 ☐ Reside	-	(Specify)
n of	ng Phy ter thi neral		27. Manner of Death 1. ☑ Naturel 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b.	Time of Injury	28c. Injury at Work?	1	w injury occurred	
Sio	tendir leath. tor: At the fu	cati	2 Accident investigat 3 Suicide 6 Could not	ho		М	1 ☐ Yes 2 ☐ No	005 1 (0)		
Division	or At efter of Direct	Certification:	4 ☐ Homicide determine	d 286. Place of in	tc. (Specify)	farm, street, facto	ory, office	City or Town		or Rural Route Number,
	To the Hospital or Attanding Physicien: The law within 24 hours felse death. To the Funeral Director akit his certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier 1 Certifying I (Check only one)	Physician: To the best aminer: On the basis of and manner st	of examination a	e, death occurre nd/or investigation	d at the time, date end place on, in my opinion, death occi	e, end due to the ca urred at the time, da	ause(s) and manna ate and place, and	er as stated. I due to the cause(s)
	To the within Fo the complex	Me	29b. Signature and title of certifier	and maintel si		2	9c. License number	29	9d. Date signed (f	Month, Day, Year)
	·		•	ann			130641	,	Januar	114 2004
	12		30. Name and address of person wh	o completed cause of	1 1		1 n	0 /4 n	va hac	14 2004 1 and 21213
			31. Date filed (Month, Day, Year)	32. Regist		man 1	TUENUE 13	~ [7(1VU)	- when	1000
	Sta Registr		18N	1 5 200 h	July 15	H. 1	meles			

			For State Registrar	State of Maryla	•	nent of H			ene 200	4 00756
	Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, La Joseph F 4a. Facility Name (If not institution, giv 50 E : 4//	rank j	Hollani 4b.		Location of Death	2. Date of Death Month January	Day Yea 5 200 4c. County of De	4 2:05+M
	Funeral Director		5. Social Security Number 228-18-9349 Usual Residence of Decedent	ex 7. Age (In yrs ★ M 2□ F		Inder 1 Year oths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. B	lirthplace (State or Foreign Country)
	e Maryland e-f show	ctor	10a. State 10b. County	10c. C	Bal	to.				10d. Inside City Limits 1 ★Yes 2 □ No
	ath with the 23a or 28 und be no	Funeral Director	10e. Street and Number 50 E, 415	+ 5+.		f. Zip Code	1218		g. Citizen of What (١,
920	within 72 hours after death with the Maryland ene. than "natural", or Itama 23a or 28a-1 show the Modical Extrainer can't be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1. Armed Forces? 1. Armed Forces? No If Yes, Give Year or Dates:		ecedent of H specify Cuba es 2 No	ispanic Origin? (Spe in, Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)	Black, Wi	nerican Indian, hite, etc.
<i>telland</i> 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if I tem 27 is marked other than "natural", or Itama 23a or 28a-1 show any injury or other traumatic event, the Marildal Examiner must be notified at ODEs.	Be Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation (de completed) College (1-4or 5+)		of work done of OT use retired	ation during most of worki	ng 10	6b. Kind of Busines	s Andustry
ank 14 yland 2	should be filed with nd Mental Hygiene marked other tha	To Be Co	17. Father's Name (First, Middle, Last, JOSEPH W				18. Mother's Name			nan
e, Mar	1 and 2 sho Health and Iom 27 ie m		19a. Informant's Name/Relationship (Lealer + 20a. Method of Disposition	tollandJon	Place of Disposition	S N	Bond	st 2	City or Town, State, 205 Oc. Location - City of	
	permit. Pages Department of I Important: If it any injury or o		1 Burial 2 Cremation 3 4 Donation 5 Other (Specifications) 21. Signature of Funeral Service Licer		cemetery, crematory C (1 50 22. Nam	nfore	st 1-1	5-04 0	wings	mills md
8	89889		23a. Pert1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea	ath. Do not enter the	mode o dyin	ss of Facility Chav's GS+CTN g, such as cardiac o	AVE r respiratory arres	. Balto.1	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Iteart Fa	quence of): Artery Dis					Oliset and Death
M	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse						
38760,	icate be executed physician and s the burial-transit		resulting in death) Last	d. Chronic C	Obstructive	Pulm	enary Dis	ease		
Division of Vital Records, P.O. Box 6	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To tha Funeral Director: After this certificate has been signed by the atlending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	tal death 3 Ector	pic pregnancy or (specify)			23d. Date of d Month	elivery Day Year
rds, P	en signed b	þ	Part II. Other significant conditions of	ontributing to death but not re	sulting in the underly	ing cause give	en in Part I.		1 11	to the cause of death? Probably 4 □Unknown
al Reco	ician: The law recentificate has be rector, page 2 sho	Completed						24a. Was an autopsy performe	24b. Were a prior to death?	
V.	sician	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatient 3□	DOA Othe	26. Place of Death			
o	g Phy er this eral d	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury Work		28d. Describe how	ce 6 Other (Sp	өсігу)
ivision	r Attendinger death. irector: After in the fun	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	ר	Injury M home, farm, street, fa	10	Yes 2 □No	28f. Location (Stre City or Town,	et and Number or F State)	Rural Route Number,
٥	To the Hospital or Attending Physician: The I within 24 hours after death. To tha Funeral Director: After this certificate ha completely filled in by the funeral director, page.	Medical Cer	29a. Certifier (Check only one)	sysician: To the best of my kn niner: On the basis of examin and manner stated.	nowledge, death occu lation and/or investiga	irred at the tim ation, in my op	ne, date and place, a pinion, death occurre	and due to the cau	se(s) and manner a	as stated. ue to the cause(s)
	To the within: To the comple	Med	29b. Signature and title of certifier	W		29c. License			1. Date signed (Mor	
	3		30. Name and address of person who Jolene Brown, M.	0 10 North	Greene Str					``
	Sta Registra		31. Date filed (Month, Day, Year) JAN 1 5 2004	32. Registrar's Sign	nature fracts					

Needled Saminer		
All Coly, Town, or Location of Death All Coly, Town, or Location of Death All Coly, Town, or Location of Death All Coly, Town, or Location of Death All Coly, Town, or Location of Death All Coly, Town, or Location of Death All Coly, Town, or Location of Death All Coly, Town, or Location of Death All Coly, Town, or Location of Death All Coly, Town, or Location of Death All Coly, Town, or Location of Death All Coly, Town, or Location All Coly, Town, and town,	Year	3. Time of Death 05:50 P M
Usual Residence of Decedent 10c. Clay. Town or Location 10c. Street and Number 10c. Clay. Town or Location 10c. Street and Number 10c. Clay. Town or Location 10c. Clay. Tow	inty of Death INCE GEO	RGE
10a. State 10b. County 1	9. Birthplac Country,	NJ
STEPHEN HOMESACK SR. STEPHEN HOMESACK SR. STEPHEN HOMESACK SR. STEPHEN HOMESACK SR. STEPHEN HOMESACK SR. STEPHEN HOMESACK DAUGHTER 19a. Informant's Name/Relationship (Type, Print) MURIEL HOMESACK DAUGHTER 20a. Method of Disposition 1	10d.	I. Inside City Limits 1 ☐ Yes 2X No
STEPHEN HOMESACK SR. STEPHEN HOMESACK SR. STEPHEN HOMESACK SR. STEPHEN HOMESACK SR. STEPHEN HOMESACK SR. STEPHEN HOMESACK DAUGHTER 19a. Informant's Name/Relationship (Type, Print) MURIEL HOMESACK DAUGHTER 20a. Method of Disposition 1	of What Country U.S.A.	n
STEPHEN HOMESACK SR. STEPHEN HOMESACK SR. STEPHEN HOMESACK SR. STEPHEN HOMESACK SR. STEPHEN HOMESACK SR. STEPHEN HOMESACK DAUGHTER 19a. Informant's Name/Relationship (Type, Print) MURIEL HOMESACK DAUGHTER 20a. Method of Disposition 1	Race - American Black, White, etc ecity: WHITE	o.
STEPHEN HOMESACK SR. STEPHEN HOMESACK SR. STEPHEN HOMESACK SR. STEPHEN HOMESACK SR. STEPHEN HOMESACK SR. STEPHEN HOMESACK DAUGHTER 19a. Informant's Name/Relationship (Type, Print) MURIEL HOMESACK DAUGHTER 20a. Method of Disposition 1	f Business/Indus AL TRANS	*
232. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	талте)	
232. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	20724	
232. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	NSVILLE :	, MD
Physician /Medical Examiner Medical Examiner M	MD 2106	61
O de to the past 12 months? 1	In	oproximate nterval Between onset and Death
d. Section Control of the section Contr		
O to be selected by the selection of the		-
	Date of delivery Month Da	
24a. Was an autopsy performed? 1		cause of death?
25. Was case referred to medical 26. Place of Death (Check only one) axaminer? Hospital:	b. Were autopsy prior to comp death? 1 \(\text{Yes} \) 2[y findings available pletion of cause of
Hospital:		
Hospital: 1 Inpatient 2 ER/Outpatient 3 DoA Cther: 4 Nursing Home 5 Residence 6 Oth		
27. Manner of Death 1		
5 8 5 9 O		
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and ma place, and due to the cause(s) and ma place, and due to the cause(s) and ma place, and due to the cause(s) and manner stated.		
29b. Signature and title of certifier 29c. License number 29d. Date signe 201 / 11	gned (Month, Da)	ay, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KAJ CHAWLA 3666 mitchell ville vd Burvie MD	207/	16
Registrar JAN 1 5 2004 DHMH 17 Rev 1/2001		

ORIGINAL

.uuz8z .rley Jo	nes	State of Manyland /						egible.	
		1- For Amend Item 8 per FH, GS2 1,01/15/04	Cer	tificate of Dea	ath	Be	g. No.	2004	00758
		Decedent's Name (First, Middle, Last)				2. Date of Deat	h		3. Time of Death
Physi		Shirley Ann Jones				January	11	2004	1050 a м
/Med Exam		4a. Fecility Name (If not institution, give street and number)		4b. City, Town, or Loca			4c. C	ounty of Death	
		1507 Bank Street 5. Social Security Number 6. Sex 7. Age (In yrs. last b	niethdau)	Baltimore	Inder 24 Hrs.	8. Date of Birth	02/16	74V a Right	plane (State or Foreign
Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs. last b) 212-48-2402 56	Yrs.		ours Min.	(Month, Day,	Year)	6 19	place (State or Foreign ntry) NOTTH 4-7 Carolina
Pu .		Usual Residence of Decedent 10a. State 10b. County 10c. City, To	um os l o	action					10d. Inside City Limits
arylar ehow	_								1 Yes 2 No
Sea-f	Directo	Maryland Balti	imor	10f. Zip Code		1.	On Citiza	on of What Cou	- 1
with t									
eath	Funeral	1507 Bank Street 11. Marital Status 12. Was Decedent Ever in U.S.	13. V	21231 Vas Decedent of Hispani Yes, specify Cuban, Me	ic Origin? (Spe			ed Sta	
fter d	Fun	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No				Rican, etc.)		Black, White,	, etc.
5-UU36 72 hours after death with the Maryland thatural; or Hems 23s or 28s-1 show dical Expiration mades contilled at	þ	3 ☐ Widowed 4 M Divorced Year or Dates:	1	☐ Yes 2 No Spe	ecity:		S	pecify: Wh:	ite
2-0 72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	a. Deced	ent's Usual Occupation kind of work done during	most of workii	ng	16b. Kind	f of Business/In	ndustry
within then the Max	jdu	Elementary/Secondary (0-12) College (1-4or 5+)		no not use retired)		Г	mac	tic & C	Commercial
Maryiand 21213-UU30 d 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene. It is marked other than "naturel", or flems 23s or 28s-f show traumatic event, the Medical Expiration materials			- COCK		Mother's Name	(First, Middle, M			
and the find	Be					Hartley		,	
Should should nd Men	2		∌b. Mailin	g Address (Street and N				Town, State, Zij	D Code)
Ma nd 2 s lith ar lith ar 27 ls			3105	Dauphine	Stree	et Silv	ver	Sprin	. 20906ar
S 1 ar f Hea item		20a. Method of Disposition 20b. Place	of Dispos	sition (Name of natory or other place)	200			ation - City or T	
Pege ento				Cemetery			Bal	timore	e, Marylar
Baltimore, Marylar permit. Peges 1 and 2 should b Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e	DUCE.	21. Signature of Funeral Service Licensee	22	Name and Address of F	FacilityDav:	id J. V	vebe	r Fune	eral Homes
n ases	8	Mathleen Weber CFSP				ter Sti			imore,
N 14	ij	23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each thin.	o not ente	er the mode of dying, suc	ch alMartrayo	Septedory arre	est, 21	231	Approximate Interval Between Onset and Death
Physicia	n	Immediate Cause (Final disease or condition	مها	Marca	do	LITH	ud	trom	Onset and Death
/Medica Examine	-	resulting in death) Due to (or as a consequence	e of):						
Examine		Sequentially list conditions, b	n +10.						
ed isit	Examiner	If any, reading to immediate cause. Enter Underlying Cause (Disease or injury	3-UI).						
60, be executed icien and burial-transit	xan	that initiated events c. Due to (or as a consequence	e of):						
/60, le be executed ysicien and e burial-transit	al								
Records, P.O. Box 687 The law requires that the death certificate ate has been signed by the attending phys bage 2 should be detached for use as the	edic								
Box sath cert attending for use a	Z	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal deal	th 3	Ectopic pregnancy			23	d. Date of deliv	•
hat the death certificated by the attending phydetached for use as the	Physician/Medi	in the past 12 months? 1 Yes 2 No 9 Unknown		Other (specify)				Month	Day Year
P.O. nat the d d by the letached	Phys	9 Unknown			5	Dog Bidan			the according to
S, T res tha signed be de	ģ	Part II. Other significant containing to could but not resulting	; in the ur	iderlying cause given in i	Paπ I.	239. Did tot	A		the cause of death?
COTC w requir been si should	ted							V.	
Hec le law has b	Completed					24a. Was a autops perform	y i	24b. Were auto prior to co death?	opsy findings available impletion of cause of
al F n: Th ncate r. pag						1 ☐ Yes	No	1 🗌 Yes	2 □ No
VISION Of VITAL Attending Physician: or death. ector: After this certifical by the funeral director.	o Be	examiner?		Other		(Check only on		Dibas (Casa)	at ccene
Of Physical this	- I		. Time of	28c. Injury at Work?		ne 5 Reside		occurred	y) at scene
On oding th. Afte	i i	1 Natural 5 Pending (Month, Day Year)	Injury	M 1 ☐ Yes	2 No	Subject	a fu	we son	on firm one
Division of Vital Records, for Attending Physician: The law requires that death. Director: After this certificate has been signs in by the funeral director, page 2 should be a	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, str	et, factory, office			reet and	Number or Run	al Route Number,
Saffe al Direction	Certification:	4 Homicide Solemines building, etc. (Specify)	TH	one		1507	BAN	K 81	7, 21231
Division of Vital Re To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this centificate ha completely filled in by the funeral director, page									
the H hin 24 the F	edical		2110001 1111						
To To	Σ	29b. Signature and title of certifier		29c. License num OCME		2		signed (Month, $uary \ 1.$	
1		(Carpeny)							
	Mellesydent altycoches	30. Name and address of person who completed cause of death (Item 23a	i) (Type,		Street	, Baltin	ore.	Maryla	and 21201
	State	31. Date filed (Month, Day, Year) 32. Registrar's Signature						- 2	
Regi			has						
			A Control of the last	477					

			7	I / Department of Health a Certificate of Death	and Mental Hygiene	°2004 00759
Phys /Me	ician dical	Decedent's Name (First, Middle, Last)	LELA	JOHNSON	2. Date of Death Month Da JGNAGM	11 2004 2:45 4.
	niner	4a. Facility Name (If not institution, give st. 5. Social Security Number 6. Sex	oeet and number) 5 Pi + 4 C 7. Age (In yrs. Ia	1 (00 / 100 / 1 / 1 00	Town 1	BACAMORE 9. Birthplace (State or Foreign
Funer Directo			M 2⊠F 7. Age (117 yrs. 12	Yrs. Months Days Hours	8. Date of Birth (Month, Day, Year	Country)
death with the Maryland ms 23e or 28a-f show rmust be maillied at	tor	10a. State 10b. County MO BAL+M	nore Ra	Town or Location		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
th with the 23e or 28: ust be nut	Funeral Director	10e. Street and Number 3530 ReSource	Or APT &	101. Zip Code 118 2//33		itizen of What Country?
	by Funer		2. Was Decedent Ever in U.S Armed Forces? 1	 13. Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexican 1 ☐ Yes 2 ☐ No Specify: 	gin? (Specify Yes or No- , Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
	Completed	(Specify only highest grade Elementary/Secondary (0-12)		16a. Decedent's Usual Occupation (Give kind of work done during mos life. DO NOT use retired)	t of working	ealth Case
be filed tal Hygind of other event, I	Be	17. Eather's Name (First, Middle, Last)	0	18. Mothe	er's Name (First, Middle, Maide	
re, IMarylar s 1 and 2 should be f Health and Menta item 27 la marked other traumatic e	2	19a, Informant's Name/Relationship (Typ	/	19b. Mailing Address (Street and Number	er or Rural Route Number, City	
or Health		20a. Method of Disposition	1 00	128 1, Deco for Language of Disposition (Name of Imperent of Imper	The second secon	ocation - City or Town, State
Pag ment ant: I	ai	1 ☑Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	Kini	g Memor al Park 22. Name and Address of Facility	1-17-04 BA	OLTIMOSE MO
Danti permit. Departir Importa any inju	SUC		ene	18728 Cherry Rd	Kundalls town is	M) 21133
Physicia	111	23a. Part1. Ent.—the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused the death cause on each line.	Do not enter the mode of dying, such as	Samy disease.	Approximate Interval Between Onset and Death
/Medic Examin	al	resulting in death)	Due to (or as a consequence Covernment)	ence ot):	ise	
icuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequ			
f 60, ate be execu hysician and the burial-tra	cai	resulting in death) Last	Due to (or as a consequ	ence or):		
J.O. BOX 68/6U, at the death certificate be executed by the attending physician and lached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3 ☐ Ectopic pregnancy		23d. Date of delivery Month Day Year
	d by Ph	Part II. Other significant conditions conf	ributing to death but not resu	liting in the underlying cause given in Part I	. 23e. Did tobacco	use contribute to the cause of death?
I Re The la ate has page 2	Comp	1			24a. Was an autopsy performed 1 Yes 2 N	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
Vital F sicien: The s certificate lirector, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 kInpatient 2 □ I	Cthor	of Death (Check only one)	6 □Other (Specify)
On of ding Phys h. After this funeral di		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury at Work? M 1 Yes 2	28d. Describe how inju	
ivisite deat virector:	rtifica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, factory, office	28f. Location (Street a City or Town, Stat	and Number or Rural Route Number, te)
To the Hospital of Within 24 hours at To the Funeral D completely filled is	Medical C	29a. Certifier Check only one) Certifying Phys	ician: To the best of my knower: On the basis of examinat and manner stated.	wiedge, death occurred at the time, date ar ion and/or investigation, in my opinion, dea	nd place, and due to the cause(sath occurred at the time, date ar	s) and manner as stated. nd place, and due to the cause(s)
To the I	₹	29b. Signature and title of certifier		29c. License number	29d. D	ate signed (Month, Day, Year)
1		30. Name and address of person who co	npleted cause of death (Item		Jan	many 11 2004
		Chipky Duetims	DI Mantal	Men Burn	e -mp. 2	106%

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

			1 - For State Registrar	State of Marylan		ment of H			ene ZUU	4 00760
	Physici /Medic		1. Decedent's Name (First, Middle, Last) WiLhiAM	J. JEL	Kins			2. Date of Death Menth	Day Year	3. Time of Death
	Examir		4a. Facility Name (If not institution, give st 3/6°02DHAM	reet and number)	41	BALTI	Location of Deat		4c. County of Deat	th
	Funeral Director		5. Social Security Number 6. Sex 2/3-38-5901 19	M 2□ F 7. Age (In yrs.		Under 1 Year onths Days	Hours Min.	8. Date of Birth (Month, Day,)	(ear) 9. Birt	hplace (State or Foreign bunty)
	Maryland 8-f show	tor	10a. State 10b. County	10c. Cit	y, Town or Locati					10d. Inside City Limits 1 Yes 2 □ No
	death with the Maryland ms 23a or 28a-f show Lindal be northfied at	rai Director	10e. Street and Number 316 5. OLD HA			101. Zip Code え/スス	4		Citizen of What Co	ountry?
0036	hours after death with the Marylar tural', or items 23e or 28e-1 show at Examinar mutal for indiffied at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 XYes 2 No / 9 If Yes, Give Year or Dates: / 0/ 19	TB If Ye	Decedent of His es, specify Cubar Yes 2 No	spanic Origin? (S n, Mexican, Puerl Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Ame Black, White Specify:	
215-01	within 72 hou ene. than "natura he Medical E	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	ation	(Give kind	's Usual Occupa d of work done di NOT use retired)	uring most of wo	rking	Sb. Kind of Business/	_
and 21	Ibe filed wintat Hygien ed other the avent, the	Be	17. Father's Name (First, Middle, Last)	ex Vivos	CA	EIF	18. Mother's Nar	me (First, Middle, Ma	SETIRE P.	TENT CENTE
Maryi	nd 2 should th and Me 27 is mark traumatio	70	19a. Informant's Name/Relationship (Type A1) 70 0 1 / M - TE	e, Print)		address (Street a	nd Number or Ru	ural Route Number, C	City or Town, State, 2	Zip Code)
Baitimore,	Pages 1 arment of Healant: If item;		20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)		Place of Disposition cometery, crematory	on (Name of	14717	Date 8 20	c. Leation - City or	Town, State
Baiti	permit. Departm Importa any inju		21. Signature of Funeral Service Licensee	dendo h.	Ho	FFMAU	s of Facility - 5 Ky	TKDA F.L.	13849	OSEN ST
	Physician /Medical		23a. Part1. Enter the disease, of compile shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	Melaska	Lic C		, such as cardiac		i,	Approximate Interval Between Onset and Death
	Examiner	ler	Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury	Due to (or as a conseq						
68760,	tificate be executed ig physician and as the buriat-transit	cal Examiner	Cause (Disease or injury that intitated events resulting in death) Last	Due to (or as a conseq	uence of):					
O. Box 68	The law requires that the death certificat ite has been signed by the attending phy agge 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	I death 3 Ect	opic pregnancy her (specify)			23d. Date of deli Month	ivery Day Year
rds, P.	w requires that been signed by should be detailed	b	Part II. Other significant conditions conti	ributing to death but not res	ulting in the under	rlying cause give	n in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Hecords,		Completed						24a. Was an autopsy performe	d? prior to death?	topsy findings available completion of cause of
Vital	ysician: Th is certificate director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Ho	spital:	ER/Outpatient :	3□ DOA Othe		th Check on one	ce 6 □Other (Spec	sife)
lon of	ding Ph h. After th funeral	ation: T	27. Mann- 1 Death 1 Platural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at	28d. Describe how		nty)
DIVISION	in Die	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Sρecif	y)		17	City or Town, :		
)	Hos Hor Bly	Medical	29a. Certifier 1 Certifying Physi (Check only 2 Medical Examine one)	cian: To the best of my kno er: On the basis of examina and manner stated.	wiedge, death och tion and/or invest	curred at the time igation, in my opi	e, date and place inion, death occu	, and due to the causered at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)
,	To the within 2 Jo the complet	Me	29b. Signature and title of certifier Fix by Culci.	Endury, de	(.A.	29c. License	788 9		Date signed (Month	
a	D* 1		30. Name and address of person who com	ppleted cause of death (Item	23a) (Type, Prin	he 49	40 ENS	TERN.,	BAGT., 4.	121224
	Sta Registr		31. Date filed (Month, Day, Year)	1 5º22004 ar's Signa	ture	4. Anse				

			For State Registrar	State of M	aryland / Depa <i>Cer</i>	irtment of H tificate of L			ene 200	4 00761
			Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physicia		Louise A.	Johnson	n .			Jan. 1:	Day Year 2 2004	
	/Medic Examin	_	4a. Fecility Name (If not institution, give stre	et and number)		4b. City, Town, or	Location of Death		4c. County of De	
	LAUIIIII	Ů.	St. Catherines N	ursing 1	Home	Emmitsh	ourg		Frederi	.ck
	Funeral		5. Social Security Number 6. Sex	7. Ag	e (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. B	irthplace (State or Foreign Country)
	Director	6	219-18-2656 ^{1□ M}	2 X) F	79 Yrs.	Months Days	nours Min.	Dec. 8,		aryland
	D		Usual Residence of Decedent						-	T
	nylan how		10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits 1 Yes 2 □ No
	B Ma	5	WV Berkele	У	Inwoo	od .				
	or 28	Jre-	10e. Street and Number			10f. Zip Code		10	g. Citizen of What (Country?
	23a	Funeral Director	103 Empire Place			2542			US	
	een seen l	ine.	11. Marital Status	Was Decedent Armed Forces?	Ever in U.S. 13.	Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - An Black, Wh	nerican Indian, nite, etc.
õ	afte or it		1 Never Married 2 Married	1 ☐ Yes 2 🔼 If Yes, Give	No .	l ☐ Yes 2 No	Specify:		Specify: T	hite
ğ	in in in in in in in in in in in in in i	d by	3 X Widowed 4 Divorced	Year or Dates:	46- 8		4:	1.4		
7	"nat	Completed	15. Decedent's Educat (Specify only highest grade co	ompleted)	(Give	lent's Usual Occupa kind of work done o DO NOT use retired,	ition luring most of wort	king	6b. Kind of Busines	sylindustry
2	withir	E D	Elementary/Secondary (0-12)	College (1-4or	5+)	okkeeper	'		Accour	nting
2	be filed within 72 hours after death with the Maryland and thygiene. d other than "natural", or items 23a or 28e-f ehow event, the Medical Examinal must be ricitified at		17. Father's Name (First, Middle, Last)	<u>L</u>		ORRECPEI	18. Mother's Nam	ne (First, Middle, Ma		
ä	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. and Mental Hygiene. and mental Hygiene. aumatic event, If a Marical Examinat must be recitived at	Be	Anton C. Athman				Jose	ohine Eli	zabeth So	hulty
Ē	houk d Me mark matic	ဥ	19a. Informant's Name/Relationship (Type,	Print)	19b. Mailir	ng Address (Street a			City or Town, State	
<u>8</u>	d 2 s th an than 7 la trau		J. Cynthia Johnson			Empire P1			25428	
w	1 and Health am 27 ither ti		20a. Method of Disposition	y Daugne	20b. Place of Dispo	sition (Name of	1	Date 2	Oc. Location - City of	or Town, State
٥	Pages nent of I int: If its iry or o		1 M Burial 2 □ Cremation 3 □ Rem	noval from State	Dulaney, crem	valley	Jan.	17,	Timon	ium MD
틀	it. Puritme		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee		Memoriál	Name and Address	2004			
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 Is marked any injury or other traumatic evonce.		1000	el J. F	lagle L	emmon Fun	eral Hom	e of Dula	ney Valle m, MD 210	inc.
			23a. Part1. Enter the disease, or complicat							Approximate
			shock, or heart failure. List only one	cause each I	ine.	1	+	, , , , , , , , , , , , , , , , , , , ,		Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	<u> </u>	eluck 5	mount	Ma-			Bweeks
	Examiner			oue to or as	a consequence f):	+0	Can	1 - 0	Sisteme	10.00
		_	Sequentially list conditions, b. =	Due to (or as	a consequence of):	one !	J area	No.	sistene	wys
	ed sit	in in	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury		,					0
	xecu and	Examiner	that initiated events c resulting in death) Last	Due to (or as	a consequence of):					
8760	icate be executed physician and s the burial-transit	a								
687	licate phys s the	edical								
×	w requires that the death certific been signed by the attending f should be detached for use as	by Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant 23c.	. If yes, outcome				1	23d. Date of d	elivery
P.O. Box	atter for u	clar	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a		Ectopic pregnancy Other (specify)			Month	Day Year
o	the d y the ched	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown						
בֿ	that ed by deta	4	Part II. Other significant conditions contri	buting to death.	out not resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute	to the cause of death?
qs	uires I sign Id be		Unheime		Sement	ha.		1 🗆 Yes	2 No 3 □	Probably 4 Unknown
Ö	w req beer shou	Completed						24a. Was an	24b. Were	autopsy findings available
ğ	has ge 2	Ę.						autopsy perform	prior to ed? death?	completion of cause of
_ 	n: Th ficate r, pa	ဝိ	OF Mean and extended to made at				00 Blace of Dec		N'	as 2□ No
Division of Vital Records,	sicia certi recto	8	25. Was case referred to medical examiner? 1 Yes 2 Yno Hos	spital:	25 5B/0	Othe		th (Check only one	nce 6 Other (Sp	
ŏ	Phys rthis raldi	-: To		28a. Date of Inj				28d. Describe hov		өөспу)
o	ding h. Afte fune	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	ny Year) Injury		(? Yes 2 □No			
<u>s</u>	Atten deal ctor y the	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of In	jury - At home, farm, str	eet, factory, office				Rural Route Number,
Š	after Dire	Certification:	4 Homicide	building, e	tc. (Specify)			City or Town,	State)	
	spite		29a. Certifier Certifying Physic	ian: To the best	of my knowledge, deat	occurred at the tim	ne, date and place	, and due to the cau	use(s) and manner	as stated.
	1 24 h	Medical	(Check only 2 Medical Examine one)	r: On the basis of and manner s		vestigation, in my op	oinion, death occu	rred at the time, dat	te and place, and d	ue to the cause(s)
	To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Me	29b. Signature and title of certifier		1 .	29c. License	number	29	d. Date signed (Mo	nth, Day, Year)
) (illa		audl	M/ D	6705)	1112	104
	6		30. Name and address of person who com	pleted cause of	death (Item 23a) (Type.	Print)	_	- A	1	NA I
	7		30. Name and address of person who com	Δ 3	10 S. Se	tan Au	e E	mmits	burg	Md 21727
	Sta	ate	31. Date filed (Month, Day, Year)		rar's Signature	ents 1			1	
	Regist	rar	JAN 1 5 2004	free Big	in St popular					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician irginia I. Johnson 2004 2 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Keysuille MARYLAND Masonic Homes Hours Min. 8. Date of Birth (Month, Day, Year)

June 16 1915 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2X F Months Days MD Yrs. 212-10-8876 88 Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1□Yes 2¬No Directo **Baltimore** Phoenix MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2807 York Manor Rd. 21131-1423 USA Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14 Bace - Amarican Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ No Specify: white Specify: <u>≽</u> 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Michael George Dietrich, Sr. Matilda Caroline Wolfe ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alfred D. Johnson, Jr. 1807 York Manor Rd., Phoenix, MD 21131 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State / 1 ☑ Byriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) 1/17/04 Oak Lawn Cemetery Baltimore, MD 21 Signature of Fund 1 Sovice Licensee 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 Lowell M. Lemmon 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical a Examiner Due to (or as a consequence of): Examine ettending physician and for use es the buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificete be exec Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) 23b. Did tobacco usa contributa to the causa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. is certificate hes been signed by the director, page 2 should be deteched 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 分Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ဥ 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: efter death. Director: After t 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Locetion (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospitai 24 hours 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 W OWIE 2 m 20

32. Registrar's Signature

Joseph

Registrar

State

31. Date filed (Month, Day, Year)

JAN 1 5 2004

		•	For State Registrar	State of Maryland		nt of Health and l te of Death	Mental Hygien Reg. No	2009	00763
	Physicia		1. Decedent's Name (First, Middle, Las	KPF	ene.		2. Date of Death Month Da		Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	4b. Cit	Town, or Location of Deat		County of Death	
	Funeral Director		ala-70-1079	X 7. Age (In yrs Is	ast birthday) If Und Month:		8. Date of Birth	9. Birthplece Country)	(State or Foreign
deeth with the Maryland	fahow ind at	. [Usual Residence of Decedent 10a. State 10b. County	10c. City	Town or Location				Inside City Limits
with the	3a or 28a il be noti	Funeral Director	10e. Street and Number	St.		ip Code	10g. C	itizen of What Country?	
	al', or Iteme 2	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 12 Yes 2 No If Yes, Give Year or Dates:	If Yes, sp	edent of Hispanic Origin? (Secrify Cuban, Mexican, Puer 212 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American I Black, White, etc. Specify: Black	ndian,
12.13 7 pidhin 7	jene. rrthen "natural", or Iteme 23a or 28a-f show the Modical Examiner must be motified at	Completed	15. Decedent's Ed (Specify only highest grade) Elementary/Secondary (0-12)		16a. Decedent's Us (Give kind of life. DO NOT	ual Occupation vork done during most of wo use retired)	rking	kind of Business/Indust tor Vehicle	
should be filed	od othe	To Be C	17. Father's Name (First, Middle, Last) James E. Ket	ene		Rober	ne (First, Middle, Maide) 10 Turne	20	
, Mar	Health and Sm 27 fe m other traum		Patricia Loyo	1 - fiance	1702 C	ss (Steet and Number or Re	Balto mo	2/2/8	
aitimore	Department of Hes Important: If Item eny injury or other once.		20a. Method of Disposition 1 □/Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify	Removal from State	lace of Disposition (Nometery, crematory of UNSVIII)	VA Cem. 1-9	-04 Cro	Cocation - City or Town,	MD
Ball	Depart Import eny in		21. Signature of Puheral Service Ucen	M	Gary	and Address of Facility PIMORCH FIH	270 Freithi	Hon Fass B	alto mo
P	hysician		23a. Part . Enter the visease, or comp shock, or hear failure. List only Immediat. Cluse (Final disease or condition	dications that caused the death one cause on each line.	-ension		c or respiratory arrest,	Int	proximaté erval Between eset and Death
	/Medical xaminer		resulting in death) Sequentially list conditions.	b. Diabet	rence of):				hour
ox 68/60,	nysicien and he burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence. Due to (or as a consequence)					
A PA	ding pl	/Medic	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnal				23d. Date of delivery	
O. BOX	0 0	Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown	1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown				Month Day	y Year
ecords, P.O	been signed by the a should be detached to	þ	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the underlying	g cause given in Part I.	23e. Did tobacco	use contribute to the c	V
r g	ate h page	Completed					24a. Was an autopsy performed? 1 Yes 2 N	24b. Were autopsy prior to comple death?	findings available etion of cause of
Vital	certificate	Be	25. Was case referred to medical examiner?	Hospital:	5DIO 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Other	ath (Check only one)	0.500	
ō	r this aral di	. To	1 ☐ Yes 2 🔏 No 27. Magner of Death	28a. Date of Injury	ER/Outpatient 3 28b. Time of	28c. Injury at Work?	fome 5 ☐ Residence 28d. Describe how inju		
Division of Vita	death. ctor: After y the funer	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		Injury M	1 ☐ Yes 2 ☐ No	28f Location (Street a	and Number or Rural Ro	oute Number
	3 5 5 5		4 Homicide determined	building, etc. (Specify	′) 		City or Town, Sta	te)	
	Fun Fun etely f	edicai	29a. Certifier (Check only 2 Medical Examone)	ysician: To the best of my kno- liner: On the basis of examinat and manner stated.	wiedge, death occurri tion and/or investigati	ed at the time, date and place on, in my opinion, death occ	e, and due to the cause(urred at the time, date ar	s) and manner as stated nd place, and due to the	a. e cause(s)
-	within 24 hours a To the Funerel I completely filled	Me	29b. Signature and title (certifier)	41	2	29c. License number		ate signed (Month, Day	r, Year)
/	7 ()		lolent a	XIIII	23a) (Type, Print)	D00535	37	1/14/0	4
	2		30. Name and address of person who Robert Linto	n, modil	Julian in	emorial H	ospital s	Baltimore	e, MD
10 mg	Sta	ite	31. Date filed (Month, Day, Year)	2004 32. Rigistrar's Signa	turg				

		-	For State Registrar	State of Marylan	-	ment of H			iene g. No. (2004	0076	L
	Physicia /Medic Examin	an al	1. Decedent's Name (First, Middle, Las George 4e. Fecility Name (If not institution, giv.	-		ene b. City, Town, or	SR Location of Deat	2. Date of Dear Month Januar	Day3	2004	3. Time of Death	A
	Funeral Director		5. Social Security Number 6. S	Pital Cent Pix 7. Age (In yrs. 1) MM 2DF 64	ast birthday)	Balt If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	. 8. Dete of Birth	Year)	Cou	place (State or Foreig ntry) y land	n
	Maryland	tor	Usual Residence of Decedent 10a. State 10b. County		y, Town or Locat Baltimor						10d. Inside City Limit	
	h with the 23a or 28 at be no	Funeral Director	10e. Street and Number 1453 Boyle Stree	et		10f. Zip Code 2123)	1		n of What Cou S.A.	ntry?	
036	72 hours after death with the Maryland naturel; or items 23s or 28s-f show diest Examinant: aust be muillied at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1		s Decedent of Hi es, specify Cubal Yes 2 X No	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		Rece - Amer Black, White Decity: W		
Maryland 21215-0036	within iene. than	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		16a Deceden (Give kin life DO Pain	nt's Usual Occupa nd of work done of NOT use retired, nter	ition luring most of wo	rking		of Business/Ir	ting Co.	
yland ;		To Be C	17. Father's Name (First, Middle, Last, Thomas	Keene			Lula	me (First, Middle, i	Cra	ig		
	s 1 and 2 should if Health and Mer item 27 Is marke other treumatic		Nora A. Regan	(Daughter)	6215	200th S			way V	Washing	ton 98387	
Baltimore,	nit. Pages 1 artment of Hi ortant: If ite injury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specif	Removal from State	yview C	tory or other place rematory	01/	16/04	Balti	imore,	Md.	
Balt	Departi Departi Importa eny inj		21. Signature of Funeral Service Lice	Comme	22. N	MC Cull 130 E.	s of Eacility y-Polyn: Fort ave	iak Funer e. Baltim	al Ho	ome P.A Md. 21	230	
	Pnysician /Medical	4	23a. Art1. Enter the disease, or com- shock, or hear failure. List only immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a conseq	nia	the mode of dying	g, such as cardia	c or respiratory arr	est,		Approximate Interval Between Onset and Death	, >
- 0	Examiner	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Chronic Due to for as a consequence of Non - Hoo	Obst.	A	e Pul		D	iscase	one year	r
9760,	ate be executed hysicien and the burial-transit	Ilcal Examiner	that initiated events resulting in death) Last	c. Due to (or as a conseq d. Dich bete	uence of):	ellitu		7 T T T T T T T T T T T T T T T T T T T		1	-ive year	<u></u>
.O. Box 68	it the death certifical by the attending phi tached for use as th	Physician/Med	1F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. II yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	t death 3 □Ed	ctopic pregnancy other (specify)			230	d. Date of deliver Month	ery Day Year	
S, P	signed d be de	by	Part II. Other significant conditions	contributing to death but not res	ulting in the unde	erlying cause give	en in Part I.				the cause of death? bably 4 □Unknow	m
al Record		Completed						24a. Was a autops perform	med2 2 2 No	24b. Were aut prior to c death? 1 ☐ Yes	opsy findings availab ompletion of cause of 2 No	ie
Vital	90	o Be	25. Was case referred to medical examiner? 1 Tyes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient	3□ DOA Othe		ath <i>(Check only or</i> Home 5 ☐ Reside		70thos (6	4.1	
of	After	\vdash	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun World		28d. Describe h			·y/	
Division	P S in E	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		ome, farm, stree	t, lactory, office		28f. Location (S. City or Town		Number or Rui	al Route Number,	
1/	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier 1 ☐ Certifying Pl (Check only one) 2 ☐ Medical Exa	hysicien: To the best of my knominer: On the basis of examinal and manner stated.	owledge, death o ation and/or inves	stigation, in my o	ne, date and place pinion, death occ	e, and due to the c urred at the time, d	ause(s) an ate and pl	nd manner as ace, and due	stated. to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	ulion, Mi		i e	5 00	i	Janu		13,200	
/	5		30. Name and address of person who		n 23a) (Type, Pr 3 0 0 1	s. Ha	nover				MD2122	
	Sta	ate	31. Date filed (Month, Pay, Year) 21	32 Registrar's Signa	ature	B)						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Yeer 6.00 PM Month **Physician** BAL KAUK 04 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner <u>Baltimore</u> 9 Adil Court Catonsville
or 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** India 1 □ M 3 € F n/a 93 Aug.4, 1910 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State r than "natural", or items 23e or 28a-f shoving Medical Examiner must be nutified at 1 Yes 2 No Catonsville Baltimore Directo Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21228 <u>India</u> Completed by Funeral 9 Adil Court 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ₩ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Asian Indian 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home Pages 1 and 2 should be filed vent of Health and Mental Hygie ant: If item 27 ie marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ၉ Uixmi Singh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Adil Court Catonsville, Maryland 21228 Sandeep Singh/Grandson Department of Health Important: If item 27 any injury or other to once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crematory 1/8/2004 Odenton Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 Thomas M00957 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician 1 theresters resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine attending physician and for use as the burial-transit Rospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12-months? Month Year ō 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached Division of Vital Records, P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Minknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 2 No 1 ☐ Yes 2 No After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Medicai Certification; To 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. Il Director: A investigation 2 Accident 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number () 17537 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DARSHAN 5 SALVIAMA ALBON WE MODNE Payed Are Balto 2/2/17 SALUJA MI) \$ 1600 DAKSHAN S. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			1 - For State Registrer	State of Marylar	•	artment of rtificate of			giene 189. No. 200	4 00766
			1. Decedent's Name (First, Middle,	Last)				2. Date of Dea Month	ith Day Yea	3. Time of Death
	Physici /Medio		Margaret	Elizabetl	n	Keye	S	January	7 13, 2004	355 PM
	Examin		4a. Facility Name (If not institution,	give street and number)		4b. City, Town,	or Location of De	eath	4c. County of D	eath
			Future Care - 01	d Court		Randa11			Baltimo	
	Funeral			5. Sex 7. Age (In yrs. 1 ☐ M 2 🛣 F		If Under 1 Year Months Days	r If Under 24 h Hours M	lin. 8. Date of Birth (Month, Da)	y, Year) 9.1	Birthplace (State or Foreign Country)
	Director		212-05-1231	1 M 2 LAF 95	Yrs.			Nov.17,		aryland
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	ty, Town or Lo	ocation				10d. Inside City Limits
	f sho	5	MD Baltin	more Woo	od1awn					1 □ Yes 2/15/No
	18a 28a	Pec	10e. Street and Number			10f. Zip Code		T	10g. Citizen of What	Country?
	3a or	٥	5404 Gradin Av	700110		2120	7		u.S. A	
	ms 2	Jera	11. Marital Status	12. Was Decedent Ever in U	.S. 13.	Was Decedent of	Hispanic Origin?	(Specify Yes or No-	14. Race - A	merican Indian,
9	or Ite	by Funeral Director	1 ☐ Never Married 2 ☐ Marrie	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give	1	If Yes, specify Cul 1 ☐ Yes 2 ☐ No		ieno Hican, etc.)	Black, W	
8	ours	βp	3 Midowed 4 □ Divorced	Year or Dates:		1 165 2 X	Specily.		Specify:	wnite
ς. Υ	within 72 hours after death with the Maryland ene. then "naturet", or Items 23a or 28a-f show he Medical Exuiting the motified at	Completed	15. Decedent's (Specify only highest	Education grade completed)	(Give	dent's Usual Occu kind of work done	during most of	working	16b. Kind of Busine	ss/Industry
21215-0036	vithin ne. hen.	ğμ	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire				_
	Hygie Ther t		8th 17. Father's Name (First, Middle, La	est)	Tele	phone Ope		Name (First, Middle,		e Company
and	od ol	Be c		gaha			E11a		mancon Garnamo,	
Ž	thould Me mark mark matic	၉	19a. Informant's Name/Relationshi	o (Tvae, Print)	19b. Mailir	na Address (Stree		Rural Route Numbe	r. City or Town. State	e. Zip Code)
Maryland	d 2 s lith ar 27 is		Mrs. Gloria Jean					Woodlawn,		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturet", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examilian must be inclined at ance.	1 3	20a. Method of Disposition	20b. F		osition (Name of matory or other pla	and the last section of th	Date	20c. Location - City	
9	Page: ento tr: If i		1√ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Pueninasi iiniii Siste		Cemeter	1	17/04	Woodlawn,	Marvland
Baltimore,	artm sorter inju	li	21. Signature of Funeral Service Li							Directors
m	Depar Depar Impo any ir		Joseph .	Kollner Moo	JJJ 8	728 Libe	rty Rd.	, Randalls	stown, MD	21133-4784
	Prrysician /Medical Examiner	ner	23a. Part. Enter the disease, or combox, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	nly one cause on each line.	eun juence of):	nia				Interval Between Onset and Death
Box 68760,	icate be executed physician and s the burial-transit	dicai Examiner	Cause (Disease or influry) that initiated events resulting in death) Last	c. Due to (or as a consequence)	(uence of):					
P.O. Box (ires that the death certifica signed by the attending ph d be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn. 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	al death 3□	∃Ectopic pregnanc ∃ Other (specify) _	;y		23d. Date of Month	delivery Day Year
	The law requires that the ate has been signed by the page 2 should be detache.	þ	Part II. Other significant condition	s contributing to death but not res	sulting in the u	nderlying cause g	Yen in Part I.	23e. Did to	` ~	o to the cause of death? Probably 4 □Unknown
Division of Vital Records,	: The law cate has b , page 2 st	Completed						24a. Whas a autop: perfor 1 ∐ Yes	sy prior	
<u> </u>	Physicien: rthis certifica ral director, p	Be	25. Was case referred to medical examiner?	Hospital:		O		Death (Check only or		-
o	Phys rthis raldi	- T	1 ☐ Yes 2 No 27. Manner of Death	1 inpatient 2	ER/Outpatier 28b. Time o	it 3 DOA	ursin	g Home 5 Resid	ence 6 ∐Other (S ow injury occurred	pecify)
on	ding h. Aftel fune	tion	1 Statural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of Injury (Month, Day Year)	Injury	W	ork? ⊒Yes 2.⊟No		,,	
Divisi	To the Hospital or Attending Physicien: The law requir within 24 hours after death. To the Funerel Director: After this certificate has been si completely illed in by the funeral director, page 2 should	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	t be 200 Blace of laiun. At h	ome, farm, str fy)			28f. Location (S City or Tow		Rural Route Number,
	the Hospital or hin 24 hours afte the Funerel Diru npletely filled in I	edicai	29a. Certifier 1 Certifying (Check only one)	Physicien: To the best of my know eminer: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurred at the t vestigation, in my	ime, date and pla opinion, death o	ace, and due to the c ccurred at the time, c	ause(s) and manner late and place, and c	as stated. lue to the cause(s)
	To the To the Comp	Ž	29b. Signature and title of certifier	^ ~			ise number	2	29d. Date signed (Mo	
			T. Ca	water		Da			1 ' 1	004
	3		30. Name and address of person w	ho completed gause of death (Iter CAWA JA &O	n 23a) (Туре,	Print) Sroad	s Driv	ie Sui	Le 101 Mells	MD21117
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	10 M		8		

		1 - For State Registrar	State of Marylar	•		nt of Health Te of Deat		lental Hy	/giene Reg. No	/ HH H	00	767
		Decedent's Name (First, Middle, Last	71)					2. Date of De	eath Dav	y Yeer	3. Time	of Death
Physic /Med		(JEORGE	KESSEL					JAN	//	2004	2:1	3 AM
Exam		4a. Fecility Name (If not institution, give	street and number)		-	Town, or Location		, ,		County of Deeth		
			AYVIEW MEDICA			eltimore		arylan		N/A		
Funera		5. Social Security Number 6. S	STM 2□F	. last birthday) Yrs.	Months	Days Hour	s Min.	8. Date of Bi (Month, D	ay, Year)	Cou	place (State ntry)	or Foreign
Directo	d.	Usual Residence of Decedent	25	113.		<u> </u>		Dec.	15,19	978 Ma	ryland	<u> </u>
land bw		10a. State 10b. County	10c. C	ity, Town or Loc	cation						10d. Inside (City Limits
Many -1 sh	ţ	Maryland Ba	ltimore				Dunda	1 ጉ			1 🗀 Yes	s 2 XNo
r 28a	Director	10e. Street and Number	20111020		10f. Zi		Dunde		10g. Cit	izen of What Cou	intry?	
h witi	ai D	7877 Saint Greg	ory Drive			21222			Ţ	Jnited S	tates	
VIAING Z1Z1D-UU3D unit be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or items 23e or 28e-f show after event, the Medical Exeminer must be notified at	by Funerai	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. V	Vas Dece Yes, spe	dent of Hispanic city Cuban, Mexi-	Origin? (Sp can, Puerto	ecify Yes or N Rican, etc.)	0+	14. Race - Amer Black, White		
s afte	y Fu	Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give		☐ Yes					Specify:		
nusit.	d b	3 Widowed 4 Divorced	Year or Dates:	162 Deced	ant's He	al Occupation			16h K	ind of Business/li	White	
To 15	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Give I	kind of wo	ork done during m ise retired)	ost of work	ing	100.10	110 01 003111033711	loustry	
withi ene.	E G	Elementary/Secondary (0-12)	College (1-4or 5+) 2 Years	Di	sabl	Бe				N/A		
Hyg ether	BeC	17. Father's Name (First, Middle, Last)	2 10010		Busi		ther's Nam	e (First, Middle	. Maiden			
land be lental ked riked ricev	ToB	George R. Kesse	1				Kath1	een Sch	nraud	ler		
Maryland 21215-UU30 d 2 should be filed within 72 hours af th and Mental Hygiene. 77 is marked other than "natural; or traumatic event, the Medical Exem		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Addres	s (Street and Num	n <i>ber</i> or Run	al Route Numb	oer, City o	or Town, State, Zi	p Code)	
and 2 and 2 ealth a n 27 is		Mrs. Kathleen Kes	sel (Mother)	787	7 Sa	int Greg	ory D	rive I	_	lk, Mary		2122
O		20a. Method of Disposition 20a Disposition 20a Disposition 20a Disposition	1	Place of Dispos cemetery, crem	sition (Na	me of other place)		Date	20c. L.	ocation - City or T	own, State	
Pages Pages nent of ant: If its ury or o		'4 □Donation o □ Other (Specifi) H	olly Hi	11 M	em. Gdns	. 1/1	4/2004	Mi	ddle Riv	er, M	D
Saltimore, permit. Pages 1 ar Department of Hea important: If item: any injury or other once.		21. Signature of Fun an Service Lice	900			nd Address of Fa		Home of	Dun	dalk, Ir	20	
n adeas		(pul	1 / Km V/	7	7922	Wise Ave	a. Di	ındalk.	Mary	yland 2	1222	
		23a. Partt. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea one cause on each line.	th. Do not ente	er the mo	de of dying, such	as cardiac	or respiratory a	arrest,		Approxima Interval Be Onset and	etween
Physician		Immediate Cause (Final disease or condition	a V FIB	ARRE	ST						Onsot and	Dogui
/Medica Examine	_	resulting in death)	Due to (or as a conse	quence of):								
		Sequentially list conditions,	b. ACTUEN	1 I A								
ed nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	DTIATE	D C	20	DUM	0447	WY				
xecut and	xan	that initiated events resulting in death) Last	c. Due to (or as a conse	quence of):	TO L	V. C.	W3811	// 1:		_		-
d / ou, cate be executed physicien and the burial-transit	alE		d							1		
oo/ ificate g phys	edical		0.						- 1-			
	by Physician/Me	IF FEMALE: 23b, Was decedent pregnant	23c. If yes, outcome of pregn							23d. Date of deliv	ery	
death cert a attendin d for use	icial	in the past 12 months?	1 Live birth 2 Fet 4 Pregnant at time of		Other (s	regnancy pecify)				Month	Day	Year
that the de ned by the a	hys	9 Unknown	9□ Unknown					-				
ures tha signed I	Jy P	Part II. Other significant conditions of	ontributing to death but not re	sulting in the un	nderlying	cause given in Pa	irt I.	23e. Did	tobacco u	use contribute to	the cause of	death?
w require	edi	BELLERS	MUSCULAR	2157	RO	HY		10	Yes 2	□No 3□Pro	bably 4]Unknown
aw request should	piet	ASTHMA						24a. Was		24b. Were aut	opsy findings	available
The lav	Completed							perf	ormed?	death?		
ian: iriffice ctor. p	Be	25. Was case referred to medical examiner?				26. Pla	ace of Deat	h (Check only	one)			
Of VITA Physician: rthis certificarial director.	10	1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient						6 ☐Other (Speci	fy)	
ng Pt fter th	ü.	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury at Work?		28d. Describe	how injur	y occurred		
ISIO Ittendii death. stor: A	cati	2 Accident investigation 3 Suicide 6 Could not be			М	1 ☐ Yes 2	□No					
UNISION OF VITAL RECORDS, P.O. I or Attending Physicien: The law requires that the d after death. Director: After this certificate has been signed by the i in by the funeral director, page 2 should be detached	Certification;	4 Homicide determined	28e. Place of Injury · At the building, etc. (Spec.	nome, farm, stre ify)	et, factor	y, office		City or To		d Number or Rur)	al Houte Nur	nber,
LIVISION OF VITAL IN CITY OF The Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		- San San San San San San San San San San		- 1-4 44			and also					
To the Hospital within 24 hours To the Funeral completely filled	Medicai		ysician: To the best of my kn niner: On the basis of examin									(s)
the thin 2 the mple	Med	29b. Signature and title of certifier	and manner stated.		29	c. License numbe	er		29d. Dat	te signed (Month,	Dav. Year)	
ĭ ¥ ¥ S			- AAD					~ 7				
+ O		30. Name and address of person who		m 23a) (Tuna 1	Print)		250	UT	J.	11110	7-	
1		ou. Ivame and address of person who	Completed cause of death (Re	iii zuaj (Type, I	ently	Large St.	- 111	Augus	B.	laine 11	71	224
+ c	tate	31. Date filed (Month, Day, Year)	32. Register's Sign	ature	4	- M a	11/1	· IVERIU	1 mil	our are me	9.6	101
Regis		1 <u>UN 1</u>	5 ZUU4 NELERINA	J 15	A DE							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2:50 M **Physician** AYMON /Medical 4b. City, Town, or Location of Death Name (If not institution, give street and number) Examiner CHESA BELAIR Under 1 Year | If Under 24 Hrs. HOJD Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day) 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. Yrs. Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Experiments. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 4 Yes 2 No Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1.5 3734 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 WNo If Yes, Give Year or Dates: Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retiged) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) IOTH 17. Father's Name (First, Middle, Last) Be RAVMOND UBINSK 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informatt's Name/Relationship (Type, Print) STREET iNSLII 20b. Place of Disposition (Name di 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Si vature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cirrhosis Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner -transit Due to (or as a consequence of): physician a s the burial-1 Box 68760. Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.O. 1 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a. Was an 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Division of Vital tha Hospital or Attending death. Diractor: within 24 hours after To the Funeral Dira

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day) State

Medical

4 🗌 Homicide

29b. Signature and title of certifier

Dakwood

120

2004. Registrat's Signature

29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

D56979

Madais Chardón 21eu Burnie, MD

Registrar

		-	For State	State of Maryland		t of Health and N e of Death		ene 2004	00769
			Registrar 1. Decedent's Name (First, Middle, Last)	Continuati	or Beath	2. Date of Death	3. 140.	3. Time of Death
	Physicia	an	21 2	_			Month	Day Year 2004	0418 AM
	/Medic		4a. Facility Name (If not institution, give	esesne	4b. City.	Town, or Location of Death		4c. County of Death	- 118
	Examin	er		Λ	Ba	Himore C	itu	N.	1/4
	.		5. Social Security Number 6. Se	x, 7. Age (In yrs. I	last birthday) If Under	1 Year If Under 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign
	Funeral Director			M 2DF	Yrs. Months	Days Hours Min.	(Month, Dey,)	- 4 Col	ntry) MI
			Usual Residence of Decedent						
	how		10a. State 10b. County	10c. City	, Town or Location				10d. Inside City Limits 1 XYes 2 □ No
	e Ma	Sto	MIDIN	1-1	DULL	imore			
	라 28 라 15 15 15 15 15 15 15 15 15 15 15 15 15 1	Director	10e. Street and Number		10f. Zip	Code	10	g. Citizen of What Cou	ntry?
	death with the Maryland	Ta l	165.N.IVW	NASTERY	Ane	2122		U	(m)
	r des	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. Was Deced	lent of Hispanic Origin? (Si city Cuban, Mexican, Puert	Decity Yes or No- Dican, etc.)	14. Race - Amer Black, White	
S	s after	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes	No Specify:		Specify:	Cack
3	72 hours natural",		15. Decedent's Ed		16a. Decedent's Usua	al Occupation	11	6b. Kind of Business/li	ndustry
Ċ	in 72	olet	(Specify only highest grad	de completed)	(Give kind of wo	rk done during most of works retired)	king	X 1 //	1
7	within jene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		NIA		10/1	-
0	Hyg other	a	17. Father's Name (First, Middle, Last)			18. Mother's Nan	ne (First, Middle, Mi	aiden Sumame)	
<u> </u>	lid be lenta ked ic ev	To B	(sevra e	Neal		Sara	h Le	SESINE	
ary	2 should and Mer ie marke aumatic		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailing Address	(Street and Number or Ru	ral Route Number,	City or Town, State, Zi	o Code)
Ξ	ges 1 and 2 should be filed within 72 hours after death with the Marylan at Health and Mental Hygiene. It of Health and Mental Hygiene. It item 27 is marked other than "natural", or itema 23a or 28a-1 show it item 27 is marked other than "natural", or itema 24 is motified at or other traumatic event, the Mudical Examiner must be notified at		TIMM.KKI B	rown	165 N	Monasta	24 Aus	Back	W 31776
o C	es 1 a of He of He fitem		20a. Netbod of Disposition 1. ■ Burial 2 □ Cremation 3 □		lace of Disposition (Nareemetery, crematory or o	ne of ther place)	Date) 2	Oc. Location - City or 1	own, State
Ē	Pages nent of int: If it iry or o		A □ Donation 5 □ Other (Specify		RRAME 1	PARK 1-11	0-04 1	MARY US	v0
<u>=</u>	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licen	set	22. Name ar	d Address of Facility	DUEIL	Flohera	2 Home
n	897 29		Mull Ell	(eweb)	4600) UBGATY	HA. E	Balgo- M	0 21201
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the deatl one cause on each line.	h. Do not enter the mod	le of dying, such as cardfac	or respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	· Hupoplast	ic Luna	5			Orisot and Journ
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):	2			
	Lxammer		Sequentially list conditions,	b. Anhyora r Due to (or as a conseq	nnios				
Т	sit ad	Examlne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	, ,	•	- dostru	as: to		
	and I-trar	хап	that initiated events resulting in death) Last	c. Due to (or as a conseq		C13911C	Criori		
8/60,	The law requires that the death certificate be executed the same been signed by the attending physician and cage 2 should be detached for use as the burial-transit								
289	icate phys s the	dical	>>>	d					
	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna				23d. Date of deli	rery
Rox	atter	clar	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d				Month	Day Year
o	by the a	hys	9 Unknown	9□ Unknown					
a,	res that igned to be det	by P	Part II. Other significant conditions of	ontributing to death but not res	ulting in the underlying o	ause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Ĕ	w require been sig should b						1 🗆 Yes	2 MN o 3 □ Pro	bably 4 Unknown
ပ္ပ	s bee	Completed					24a. Was an autopsy		opsy findings available empletion of cause of
Division of Vital Records,	The lav	Eo					perform	ed? death? ☑No 1 ☐ Yes	
<u>a</u>	ician: Th certificate rector, pag	Be C	25. Was case referred to medical			26. Place of Dea	ath (Check only one)	
>	Physici this ce al direc	To	examiner? 1 🗌 Yes 2 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3 D	OA Cthen: 4 Nursing H	lome 5 Resider	nce 6 Other (Spec	rfy)
0	ding Ph h. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe hov	w injury occurred	
0	death. ctor: Af	atle	2 Accident investigation		М	1 Yes 2 No			
ž	l or Attendater deatl Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, factor fy)	y, office	28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	ital c								
1	To the Nospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	(Check only 2 Medical Exar	ysician: To the best of my kno niner: On the basis of examina					
/	the 2 the 2 the mplet	Med	ane) 29b. Signature and title of certifier	and manner stated.	29	c. License number	29	d. Date signed (Month	, Day, Year)
	D S S	1	RolandTol	SCOMD				•	
	11		30. Name and address of person who	completed cause of death (line	m 23a) (Tune Print)			101	
	V				UMMS -	22 S.Gree	ene St	Baltimo	re MD2170
<i>\$</i> 17	Str	ate	31. Date filed (Month, Day, Year)	32, Registrir's Signa	ature 2		3,		
	Regist		JAN 1	5 ZUU4 > 2500	W B. 60	and the same of th			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item #1 per phy G827 1/15/0 Certificate of Death Reg. No. CULL 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dey Year Chauncey L. Lindsey **Physician** JAN 11-00 A.M /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner Genisis Elder Care Randallstown Baltimore Randallstown H Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/02/1942 If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Deys 1 XM 2 □ F YES Maryland Director 218-40-1803 Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours efter death with the Marylend nent of Health end Mentel Hygiene. Int: If Itam 27 is marked other than "natural, or Itams 23s or 28s-f show 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Pikesville Director Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 7209 Charlkstone Avenue 21208 A 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Status Black, White, etc. 1 XYes 2 ☐ No If Yes, Give Year or Detes: 1 ☐ Never Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify Specify: à 3 ☐ Widowed 4 ☐ Divorced **Black** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) BG&E12 Customer Service Representative 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be Sarah Katherine Lindsey Milton Gardner 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 7209 Chalkstone Ave., Pikesville, Maryland 21208 Bernice Lindsey / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Depertment of the Important: If its any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. 1/15/04 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility The Derrick C. Jones F/H, F.A. 21. Signature of Funeral Service 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications in a caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical LUNG CARCINOMA Examiner Physician/Medical Examiner BRAIN METASTASES Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes Jano 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) မှ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury et Work? 27. Menner of Deeth 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medicai Certification: 1. Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation death. i Director: A 2 ☐ Accident

Division of Vital Records, P.O. Box 68760, To the Hospital
within 24 hours of
To the Funeral Completely filled

3 ☐ Suicide 4 Thomicide

29a. Certifier

29b. Signeture and title of certifier

31. Dete filed (Month, Day, Year)

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

32 Registrer's Signature

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

LCertifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated. (Check only one)

work MD

D005315D

JAN 179 2004

29d. Date signed (Month, Day, Year)

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) GUBTA SHARUNMALA

201709 BACCI RIVER NECLIND

State Registrar

Carlotte State of

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 1 5 2004

3

oatient Known

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Year John R. Linkowich 1940 P M January 12 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 10 A Swamp Scott Ct. Parkville Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 16,1953 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1⊠M 2□F 216 58 3691 50 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Mudical Examiner must be notified at 10d. Inside City Limits Maryland Baltimore Parkville Director 1 ☐ Yes 2√2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 A Swamp Scott Ct. 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Cosmotologist Salon 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be f h and Menta! h Michael Linkowich Carlotta Feeser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mit. Pages 1 and 2 sh partment of Health and cortant: If item 27 Is m Charles Linkowich (Brother) 9770 Red Clover Ct. Baltimore, Md. 21234 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or Gardens Of Faith Cemetery 1/15/2004 Baltimore, Md. ' 4 □ Donation 5 □ Other (Specify) 21. Sign there of Juneral Service License 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. ionn 1407 Old Eastern Avenue Essex, Md. 21221 Port1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End Stage Liver Disease Physician disease or condition resulting in death) Lyear /Medical Due to (or as consequence of) Examiner 14440818 0+ Syears Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed and physician ar s the burial-to Due to (or as a consequence of): Box 68760. Physician/Medical as the attending IF FEMALE use a 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ξ in the past 12 months? Month Day Year 5 Other (specify) P.O. 1 Yes 2 No 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Jas autopsy performed page certificate 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of Certification: 28c. Injury at 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending after death.

Director: Aff 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D18667 Deput January 13,2004 30. Name and address of person who completed cause of death Item 23a) (Type, Print) Philip Militello, MD
31. Date filed (Month, Day, Year) 6 Trimble Hill CT. Lutherville, Maryland 21093 32 Registrar's Signature State JAN 1 5 2004 Registrar

Physici	an_	1 - For Amend Item #7,p Registrar 1. Decedent's Neme (First, Middle, L. Theolore	ast)				2. Date of Deat Month	h Dey Yeer	
/Media	al		M Luca	3	4h City Town or	Location of Death	Jan	8 200 4c. County of Dea	1 2 11
Examir	er	4a. Facility Name (If not institution, gi		//	4b. City, Town, or	Location of Death		Howar	"n
- ·		5. Social Security Number 6.	fy General 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Dey,		rthplace (State or Fore
Funeral Director		027-10-5433 Usuel Residence of Decedent	1∰M 2□F 85	84 Yrs.	Months Days	Hours Min.	03/05/		ine
show	5	10a. State 10b. County		y. Town or Lo lumbia					10d. Inside City Lir 1 ☐ Yes 2X
r 28a-f	Director	MD Howard 10e. Street and Number			10f. Zip Code			0g. Citizen of What C	country?
23a c		7110 MInstrel	Way		21045			USA	
ei', or items 23a or 28a-f show Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1▼Yes 2 □ No If Yes, Give Year or Dates: WW		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes X☐ No	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: W	ite, etc.
'neturel', or dical Exam	eted b	15. Decedent's l	Education	16a. Deced	lent's Usual Occupa	luring most of worki	ing	16b. Kind of Busines	s/Industry
then then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		oo Not use retired dget ana			Fed. Gov	
Hyge the	BeC	17. Father's Name (First, Middle, Las	2 yr s	• Du		18. Mother's Name	First, Middle, M	Maiden Sumame)	
	2	Michael Ralph				Mary Ver	onica	Lukauska	S
ilth and Mer 27 is marker r traumatic		19a. Informant's Name/Relationship Michale L. Smi		19b. Mailir	spring Address <i>(Str</i> eet a	and Number or Rura Bloom Dr	iroute Number Tive, M	City or Town, State, illersvi	lle, Md.
the st		20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of natory or other place			20c. Location - City of	
		1 ☐ Burial 2 ☑ Temation 3 1 ☐ Donation 5 ☐ Other (Spec	ify) Ba	lto/W	ash. Cr	ematory	1/2004 _L	aurel, M	d.
Department Important: any injury page.		21. Signature of Funeral Service Clo	,—	5	555 Twi	n Knolls	Rd. C	eral Hom olumbia,	es, Inc. Md. 21
77		23a. Part1. Enter the disease, r on shock, or heart failure. List on	nplications that caused the deat y one cause on each line.	h. Do not ent	er the mode of dyin	g, such as cardiac o	or respiratory arre	est,	Approximate Interval Betwee Onset and Dear
ysician Aedical		Immediate Cause (Final disease or condition resulting in death)	a. Sepsis						1 Dag
aminer			Due to (or is a conseq						1 00
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq						7
attending physician and for use as the burial-transit	cal Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	uence of):					
the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregni 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c 9 □ Unknown	ıl death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
signed by d be detac		Part II. Other significant conditions	*	-				pacco use contribute	
houl	eted	Hepatitis C, A.	cute Menso!	Milu	2, 34	ox/(Probably 4 20nkr
8 6	Completed by	0	Backerens					y prior to death?	autopsy findings avai completion of cause is 2 No
certif	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 12 Inpatient 2	ER/Outpatier	nt 3 DOA Oth	er: 4 Nursing Ho		e) ence 6 □Other (Sp	eciful
After this funeral di		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Yeer)	28b. Time o		/ at		w injury occurred	ouny)
within 24 hours after death. To the Funeral Director; After this certificate his completely filled in by the funeral director, page	Certification:	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be as Bloom of Injury . At h	ome, farm, str		Yes 2□No	28f. Location (St City or Town	reet and Number or I 1, State)	Rural Route Number
within 24 hours after death To the Funeral Director: completely filled in by the			Physician: To the best of my known in the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of the						
thin 24 the F mplete	Medical	29b. Signature and title of certifier	and manner stated.		29c. Licensi			9d. Date signed (Mor	
	_		/- N	20	Du			Jan 8,	-
3 i 8				/ ()	リリン エル	$\alpha (Z/)$	i		2004

			For State Registrar	State of Marylan	d / Depa <i>Cer</i>	artment o	f Health a of Death	and Mer		ene 2 g. No.	004	00774
	Physicia	an	1. Decedent's Name (First, Middle, Last)	David N. M	orris			2.	Date of Death Month	Day	Year 2004	3. Time of Death 10:03 a.M
	/Medic		4a. Facility Name (If not institution, give s		OIIIS	4b. City, Tow	m, or Location of	of Death	1		ty of Death	10103 01
	- Admini	Ŭ.	736 N. Edgewo	od Street			Ltimore			N/		
	Funeral Director		5. Social Security Number 6. Sex 495–16–5069	7. Age (In yrs	last birthday) Yrs.	If Under 1 Y Months Da	ear If Under 2 ays Hours	24 Hrs. 8. Min.	Dete of Birth (Month, Day, 10-30-	Year) -1919	9. Birth	place (State or Foreign ntry) AR
	pu >		Usuel Residence of Decedent 10a. State 10b. County	10c Cib	y, Town or Lo	cation						10d. Inside City Limits
	daryla f ehor	5	,		Balto	oution.						1 X Yes 2 □ No
	r 28a-	Director	10e. Street and Number		Barto	10f. Zip Co	de		10	g. Citizen o	f What Cou	ntry?
	th with	alD	736 N. Edgewood	Street			1229				US	
36	should be filed within 72 hours after death with the Maryland of Mental Hyglene. marked other than "naturel", or items 23a or 28a-f ehow marked other than "naturel", or liter read by notified at marked event, the Madical Examination.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 NWidowed 4 Divorced	 12. Was Decedent Ever in U. Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates: 		r Yes, specify	of Hispanic Orig Cuban, Mexican, No Specify:	gin? (Specify i, Puerto Ric	y Yes or No- an, etc.)	ВІ	ace - Ameriack, White,	etc.
9	2 hour		15. Decedent's Edu	cation	16a. Deced	dent's Usual O	ccupation		1	6b. Kind of		
215	filed within 72 Hygiene. other than "nat ent, the Madic	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	life. I	DO NOT use re		_	A	berde	en Pr	oving
2	filed wil Hygien other th		12th grade	N/A	Transp	ortatio	on Drive		First, Middle, M			
Maryland 21215-0036	ould be fi Mental H arked ot atic ever	Be C	Moses Morris					nda Ne		algeri Surriz	1110)	
ary Z	should and Me a mark umath	2	19a. Informant's Name/Relationship (Ty	oe, Print)	19b. Mailir	ng Address (St	reet and Number			City or Tow	n, State, Zij	o Code)
Ž	and 2 salth a n 27 Is		Marie Kane - Daug		_		le Hall			-		
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked eny injury or other traumatic es		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ P	emoval from State	emetery, cren	sition (Name of matory or other	place)	Date		0c. Location		
Ē	ntmen rtant: njury		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License			NATIO	NAL :	1/14/2	2004 <u> </u>	BALTIN WEST		MD
Ba	perm Depa Impo eny i		leme 4.	I hum wow		. Namo and A	·	· IICI	ash Ave			Md 21215
			23a. Part 1 Enter the disease, or compleshoot, or heart failure. List only or	cations that caused the deat	h. Do not ent	er the mode of					ĺ	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	(1)	z v Li	,44	heros	scle	rosi	2		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq		~ . /	heros	10.	71'1			
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	uence of):);a6	2445	MH	2///2	<u> </u>		
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq	148h	sion	,					
Ö,	ate be executed obysician and the burial-transif	Exa	resulting in death) Last									
8760,	ficate be executed physician and is the burial-transit	dical		- Hypei	-lige	den	100					
9 x	eath certifi attending for use as	√Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna						23d. D	ate of deliv	ery
O. Box	The law requires that the death certific the has been signed by the attending Foage 2 should be detached for use as	by Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown	1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown		□Ectopic pregn □ Other (specif				٨	Month	Day Year
α.	res that igned b	by PI	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	nderlying caus	e given in Part I.			_		the cause of death?
brd	w require been sign		- Kaposi	Darcom	Ch				1 □ Ye:	s 2 No	3 🗌 Pro	bably 4 Munknown
Division of Vital Records,		Completed	Cerebrei	inactor	1)11	ECILE			24a. Was an autopsy perform 1 ☐ Yes 2	,	prior to co death? 1 \(\sum \) Yes	opsy findings available ompletion of cause of
Vita Vita	Physician: The ribis certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:			Other		Check only one			-
ō	Phys or this oral di	7: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Injury	28b. Time of		Injury at	irsing Home 28d	J. Describe how	winjury occi		fy)
Ö	Attending r death. ector: After y the fune	atlo	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	М	Work? 1 ☐ Yes 2 ☐ N	No				
Divis	in the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	(y)				City or Town,	State)		al Route Number,
1/	To the Hospital within 24 hours a To the Funeral Completely filled	edical	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my knowner: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurred at to vestigation, in	he time, date and my opinion, deat	d place, and th occurred	d due to the ca at the time, da	use(s) and r te and place	manner as s e, and due t	stated. to the cause(s)
	Fo the vithin 2 Fo the comple	Med	29b. Signature and title of certifier	and married stated.		29c. Li	cense number		29	d. Date sign	ned (Month,	Dey, Year)
	/ (Sanlestofe			D	3506	9		1/13/	104	
5	141		30. Name and address of person who co	empleted cause of death (Iter	n 23a) (Type,	Print)	6 1	1	1 . 1. 1	1	R.	1
	V		31. Date filed (Month, Day, Year)	S rzm, m D	sture %	1000	wyma.	n re	aill Di	r. 1	DALY	smove_
	Pogiet	ate	JAN 1	5 ZUU4 _ ZUZZZZZ	as to	Sen Garage						

		<u>.</u>	1 - For State Registrar	State of Mar	ryland	•	artmen rtificat			and M	-	giene leg. No. 20	04	00775
	Physici	an	Decedent's Name (First, Middle, Last) M	arjorie	L.	Me]	lka				2. Date of Dea Jan			3. Time of Death
	/Medic Examin		4e. Fecility Name (If not institution, give s					Town, or	Location o	of Death		4c. County		
			6926 Gunder Av						ltim			Bal	time	ore
	Funeral Director		5. Sociat Security Number 6. Sex 1 □	7. Age ((In yrs. las: 72		If Under Months	1 Year Days	Hours	Min.	8. Date of Birth (Month, Day Aug 2	1,1931	9. Birth Cou P.F	nplace (State or Foreign untry)
	D		Usual Residence of Decedent		10- Cit. 7									404 1-24-03-12-3
	Marylar -1 show	tor	MD Baltim	i	10c. City, T	own or Lo	cation	Mid	dle	Rive	er			10d. Inside City Limits 1 ☐ Yes 2 X No
	or 288	Director	10e. Street and Number				10f. Zip	Code				10g. Citizen of	What Co	untry?
	ath wi	ral	6926 Gunder A					212				USA		
920	77 hours after death with the Maryland "natural", or Itame 23a or 28a-f show cafeal Exercities to a positied at	by Funeral	11. Marital Status 1 Never Married 27 Married 3 Widowed 4 Divorced	 Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 			Was Deced If Yes, spec 1 \(\sum \text{Yes}\)		spanic Origin, Mexican Specify:	gin? (Spe i, P <i>u</i> erto i	ecify Yes or No- Rican, etc.)	Bla	e - Amer ck, White Whi	
2-0	72 hor	ted	15. Decedent's Educ (Specify only highest grade	ation completed)	1	16a. Dece	dent's Usua	al Occupa	tion	of worki	na	16b. Kind of B	usiness/l	ndustry
2121	J withir jiene. r then	Completed	Elementary/Secondary (0-12) 12th	College (1-4or 5+))		kind of wo DO NOT us emake		Jing moor		9	own h	ome	
Maryland 21215-0036	d 2 should be filed th and Mental Hygi ? Is marked other treumatic svsnt, I	To Be C	17. Father's Name (First, Middle, Last) Daniel Barnh	art							(First, Middle, Davis	Maiden Suman	пе)	
Mary	nd 2 should Ith and Men 27 Is marke 1 treumatic	1 13	19a. Informant's Name/Relationship (Type James Melka/hus				_				<i>IR</i> oute Number Baltimo	-		
re,	ges 1 and 2 it of Health if item 27 or other tre		20a. Method of Disposition		20b. Plac	e of Dispo	osition (Nar	ne of	Ţ			20c. Location -		
imo	Pages ment of I ent: If its ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re `4 ☐ Donation 5 ☐ Other (Specify)	moval from State	Hol	lyHi	lllCe	emet	ery	-		Balt		
Baltimore,	permit. Page Department Importent: If any injury or once.		21. Signature of Funeral Service Licen	mell	11		30	0 Ma	ice ?	Ave.	Balti	more N	LHom MD 2	neofEssex
8760,	Physician /Medical Examiner por portions of the provided	dical Examiner	23a. Part 1. Enter the disease, of complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequer consequer	nce of):	elen	e	1		kins 7			Approximate Interval Between Onset and Death Own Flagrand Death Own Fl
.O. Box 6	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physiclan/Medlo	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ic. If yes, outcome of 1 Live birth 2 4 Pregnant at tir 9 Unknown	☐ Fetat de	ath 3[□Ectopic pr □ Other (sp						te of deliventh	very Day Year
Ω.		þ	Part II. Other significent conditions conf	ributing to death but	not resultin	ng in the u	nderlying c	ause give	n in Part I.		23e. Did to	34		the cause of death?
Vital Records,	ien: The law requires rtificate has been sign stor, page 2 should be	Completed									24a. Was a autops perform	sy med?	Were aut prior to co death? 1 Yes	opsy findings available ompletion of cause of
∠it	5 6 9	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 ☐ Inpatient	2 EB	I/Outpation	nt 3 🗆 DC	Othe		of Death	(Check only or		05/6000	4.3
n of		H	27. Manner of Peath	28a. Date of Injury (Month, Day)	28	Bb. Time o		8c. Injury Work	at		28d. Describe h	ence 6 □Oth ow injury occur		пуј
Division	ten death tor: the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury	y - At home (Specify)	e, farm, sti	M reet, factory		′es 2 🗆 !		28f. Location (Si City or Town	treet and Numb n, State)	er or Rui	ral Route Number,
0	To the Hospitel or Al within 24 hours after of To the Funerel Direc completely filled in by		29a. Certifier Certifying Phys	ician: To the best of	my knowle	odge, deat	h occurred	at the time	e, date an	d place, a	and due to the c	ause(s) and ma	anner as	stated.
	the H in 24 the Fi	ledical	one)	er: On the basis of e and manner state	examination ed.	arrovor in				ui occ <i>u</i> rre				· ·
)	Veith Com	Σ	29b. Signature and title of certifier	aluhi	111	m		License 12		6		9d. Date signe		
	1		30. Name and address of person who con	npleted care of dea	ath (Item 23	3a) (Type,	Print)		, , ,		9000	Front	G	2, 2004 md21237
	V			FIELD	m	0	for	akla	53	Hosp	sifal Ct	4 /	Ball	mol 21237
	Sta Registi		31. Date filed (Month, Day, Year)	2004 No	s Signatur	B.	STA	A. J.	0					

			For State Registrar		f Marylan	id / Depa		of H	ealth a		ental Hy		200	4 007	76
ı	Physicia		1. Decedent's Name (First, Middle, La Hazel Wentwo	-	ller						2. Date of De. Month Januar	Day			
	/Medio Examin	er	4a. Facility Name (If not institution, gi Shanti Home	e street and nur			Laui	rel	Location o			4c. P1	County of De	Georges	
ĺ.	Funeral Director			Sex 1□M 270 F	7. Age (In yrs. 97	last birthday) Yrs.	If Under Months	Days	If Under	Min.	8. Date of Birt (Month, Da MAY 14	y, Year) 19(06 Wa	Birthplece (State or F Country) Shington	oreign DC
	death with the Maryland ims 23a or 28e-f show	tor	10a. State 10b. County Maryland Prince	Georges		y, Town or Lo	ocation					-		10d. Inside City I	
	h with the 23a or 28e	ai Directo	10e. Street and Number 6410 Old Sandy S		oad		10f. Zip	Code 707				10g. Citi USA	izen of What	Country?	
336	172 hours after death with the Marylan "natural", or Items 23a or 28a-f show olical Exer'ulter charal Le notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Dece Armed Fo 1 ☐ Yes If Yes, Gin Year or D	e	1	Was Deced If Yes, spec 1 Pes 2		spanic Origin, Mexican Specify:	gin? (Spe i, Puerto F	cify Yes or No Rican, etc.)	-	14. Race · Ar Black, Wi Specify:	merican Indian, hite, etc. White	
Maryland 21215-0036		Completed	15. Decedent's E (Specify only highest g. Elementary/Secondary (0-12)	ducation ade completed) College (1	-4or 5+)	16a. Dece (Give life. Homem	dent's Usua kind of word DO NOT us aker	l Occupa k done d e retired	ation <i>furi</i> ng mosi)	t of workin	g		ind of Busines Home	ss/Industry	
lang z	be d	To Be Co	17. Father's Name (First, Middle, Las Willie Bryant E			110					(First, Middle.	Maiden	Sumame)		
	s 1 and 2 should I Health and Men Itam 27 is marke other treumatic		19a. Informant's Name/Relationship Helen L. Braffor			1470	4 Haro	old	Road		Route Number			, <i>Zip Code)</i> 20905	
Baitimore,	m O .		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Spec	<i>fy</i>)	State	Place of Dispo cemetery, crea tro Cr	ematoi	cy I	nc.	1-14		Ba	ltimor	or Town, State	
Pair	permit. Page Department of important: If any injury or		21. Signature Funeral Service Lice Folward A. Gr	egorchil			299 F1	reae	rick	koad	of MD Balt	clmo	re, MD	21228	
	Physician /Medical		23a. Part1. Enter the disease, or conshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	a	aused the deal ach line.	vy T						rrest,		Approximate Interval Betwee Onset and Dec	ath
慢	Examiner pu	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events	c.	or as a consec										
68/60,	icate be executed physician and s the burial-transit	ical	resulting in death) Last	Due to	or as a consec	quence of):									
O. Box	The law requires that the death certificate the has been signed by the attending phy agge 2 should be delached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 ☐ Live b	come of pregna pirth 2 ☐ Fete lant at time of co lown	el death 3	Ectopic pre Other (spe						23d. Date of o Month	delivery Day Yea	àr
rds, P.	quires that n signed b uld be deta	d by Pr	Part II. Other significant conditions	•		sulting in the u	nderlying ca	iuse give	en in Part I.		23e. Did to			to the cause of dea Probably 4 Dunk	
Hecords,		Completed	!								24a. Was autor perfo 1 \(\text{Yes} \)		prior t	autopsy findings avo o completion of cause? es 2 \(\square\) No	ailable se of
of Vital	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death		Inpatient 2 of Injury th, Day Year)	ER/Outpatien	-	A Other	er: 4 □ Nu	rsing Hon	(Check only one 5 Resided Resi	dence	-	pecify) TOU	hame
Division of	i or Attending P after death. Director: After I I in by the funera	Certification;	1 Natural 5 Pending investigati 3 Suicide 6 Could not determine	on be 28e. Place	of Injury · At h	ome, farm, st	M reet, factory	10	Yes 2□	-	8f. Location (S City or Tox			Rural Route Numbe	·,
- -	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical Co	29a. Certifier 1 Certifying R (Check only one) 2 Medical Exc	iminer: On the b	a best of my kno asis of examina ner stated.	owledge, deat ation and/or in	h occurred a vestigation,	at the tim	ne, date an pinion, dea	d place, a	and due to the ad at the time,	cause(s) date and	and manner i place, and d	as stated. ue to the cause(s)	
	within To th	Me	29b. Signature and title of certifier	fecu	eleo	me	29c) O	number 036	71	6	29d. Dat Janu	te signed (Mo Jary 14	nth, Day, Year) 4, 2004	
	V		30. Name and address of person when the work of the work of the same and address of person when the same and address of the same address of the same and address of the same address of the sa	nd rat	se of death (Itel	m 23a) (Type.	Print) 3/7	Ch	epp	7 6	lane	6	aure	14, 2004 14, 2004	2707
Di	Sta Regist		JAN 1	5 2004	George	J. J.	Amer	63							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month MORGAN Day Year **Physician** WILLIAM 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner BALTIMORE HOSPITAL BALTIMORE HARBOR CENTER If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months 1₩ 2□F 85 Oct.31 1918 Director 215-01-3117 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be nutilised at 1 X Yes 2 ☐ No Baltimore n/a Director Md. 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 0 U.S.A. 21230 1469 Stevenson Street or Items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □XYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Bethlehem Steel then " Elementary/Secondary (0-12) College (1-4or 5+) nit Pages 1 and 2 should be filed withi arment of Health and Mental Hygiene. ortant: if Item 27 is marked other ther in ury or other traumatic event, the M Key Highway Ship Yard Worker 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Soth William Τ. Morgan Margaret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $1469\ \, {
m Stevenson}\ \, {
m Street},\ \, {
m Baltimore},\ \, {
m Md}$. 21230Florence M. Morgan (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any in ury or Cedar Hill Cemetery 01/17/2004 Baltimore, Md. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Polyniak Funeral Home P.A. DDC8 m00922 3204 Mountain Road, Pasadena, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on each line. Approximate Interval Between ASPIRATION Onset and Death PNEOMONIA Immediate Cause (Final disease or condition resulting in death) days **Physician** /Medical Due to (or as a consequence of) Examiner SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner al or Attending Physician: The law requires that the death certificate be executed after death.

In the After this certificate has been signed by the attending physician and birector. After this certificate has been signed by the attending physician and in by the function page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ARTERY DISTASE COLON CANCER 1 Yes 2 No 3 Probably 4 Unknown Be Completed INFECTION 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 ☐ Yes 2 17 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 VInpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours a To the Funeral E Rospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STREET, BALTIMORE, HANOVER 3001 SOUTH 31. Date filed (Month Cay, Year) 2004 32. Segistrar's Signature State Registrar

		-	For State Registrar	State of Maryl		artment of F rtificate of			ene 2 0 0 4	00778
	Physicia	an	1. Decedent's Name (First, Middle, Last) Margaret Adeline	Musgrove				2. Date of Death Month January	10°, 2ď04	3. Time of Death 10:10P.M
	/Medic Examin	· ·	4a. Facility Name (If not institution, give str				r Location of Death	1	4c. County of Death	
			113 South Hilltop 3 5. Social Security Number 6. Sex		vrs. last birthday)	Catonsv If Under 1 Year	rille If Under 24 Hrs.	8. Date of Birth	Baltimore	place (State or Foreign
	Funeral Director			2 2 F 95	Yrs.	Months Days	Hours Min.	August 1	4,1908 Mary	land
	DU N		Usual Residence of Decedent 10a, State 10b, County	100	. City, Town or Lo	cation				10d. Inside City Limits
	Maryla	tor	Maryland Baltimore		atonsvil					1 ☐ Yes 2 📉 No
	or 28e	irec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	ntry?
	death with the Maryland ms 23a or 28e-f show fraust be notified at	rai	113 South Hilltop Ro	oad 2. Was Decedent Ever	in 11 S 13 Y	21228 Was Decedent of H	lispanic Origin? (Si	necity Yes or No-	U.S.A.	can Indian.
٥	atter or ite	Funeral	11. Marital Status 1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give	'	If Yes, specify Cuba	Specify:	o Rican, etc.)	Black, White	etc.
3	hours a	d by	3 X Widowed 4 □ Divorced	Year or Dates:		dent's Usual Occup			6b. Kind of Business/Ir	ite
	within 72 ene. then "nat	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of wor.	king	OD. THIS OF EGSINGS	idd dii y
N	ygiene /giene rer the	Com	6		Home	maker		(C) 1 (C) (C)	Own Home	
land		Be	17. Father's Name (First, Middle, Last) John	Reyn	olds		Henriet	ne <i>(First, Middle, M</i> ta	a <i>iden Sumame)</i> S i mo	ns
Mary	2 should and Men is marke eumatic	10	19a. Informant's Name/Relationship (Type	e, Print)					City or Town, State, Zi	
_	s 1 and 2 f Health (item 27 i	1	June A. Ward (daug		113 S		Road, C		e, Marylan Oc. Location - City or T	
n 0	m O >		20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation 3 ☐ Rei 1 ♣ Donation 5 ☐ Other (Specify)	mayal from State	cemetery, crei	matory or other plac			lays Chapel	
Baltimore,	permit. Page Deportment of Importent: if any injury or		21. Signature of Funeral Service Licenses	2	Š	Name and Addre	ss of Facility Shton-Sc	hwab Fune	eral Home, Lle, Maryl	Inc.
· 2			23a. Part Enter the disease, or complices ck, or heart failure. List only one	ations that caused the						Approximate Interval Between
	nysician		I rediate Cause (Final	Ischem	ic C	ARDION	LYCDATO	HY END.	STAGE	Onset and Death 6 WONTH
	/Medical Examiner		resulting in death)	Due to (or as a co	nsequence of):		/ V	RT Dise		Ricalac
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co		/			ASE C	TYEARS
	ecuted and transit	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	Gener Due to (or as a co	Alized	& ATHE	e roscle	2 pesis	Ž	O YEARS
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai E		Dao 10 (01 43 4 00	nsoquoneo on.					/
687	rificate ng phy: as the	a a	IC CENTALE.							
Вох	death certifical attending plants as 1	Physician/M	in the past 12_months?	c. If yes, outcome of pi 1 Live birth 2 4 4 Pregnant at time	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of delive Month	ery Day Year
o.	that the de led by the a detached f	nysic	1 □ Yes 2 🖾 No 9 □ Unknown	9 Unknown	or death St					
S,	uires that signed k	by P	Part II. Other significant conditions cont	ributing to death but no		inderlying cause given BR	. 4		acco use contribute to	
ord	w require been si should b	eted	severe Emply	ISEMA.	Cupe	MIC DR	CPCUTT!	1 TYe		bably 4 Unknown
Rec	sician: The law certificate has t irector, page 2 s	Completed by						autopsy perform	prior to co	opsy findings available empletion of cause of
ta	ian: T rtificate ctor, pe	Be Co	25. Was case referred to medical				26. Place of Dea	1 Yes 2 ath (Check only one	2.7	2010
>	Physician: r this certific ral director,	မ	1 Tes ZIZINO	ospital:	2 ER/Outpatie	nt 3 DOA	1242		nce 6 Other (Spec	fy)
ono	ding P	tion:	27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Ye	ar) 28b. Time o	Wo	ryat rk? }Yes 2 □ No	28d. Describe ho	w injury occurred	
Division of Vital Records,	To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury · building, etc. (S		reet, factory, office		28f. Location (Str City or Town	eet and Number or Rui , State)	al Route Number,
_	To the Hospitei within 24 hours a To the Funerel I completely filled	Medical C	29a. Certifier 1 Certifying Physi (Check only one) 2 Medical Exemin-	ician: To the best of m er: On the basis of exa and manner stated.	y knowledge, deat amination and/or in	th occurred at the travestigation, in my o	me, date and place opinion, death occu	e, and due to the ca arred at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
	To the within to the comple	Mec	29b. Signature and title of certifier		().	29c. Licens			d. Date signed (Month	
)			Mugas)	ATTENDI	NG Phy	SKIMN L	1620	O JA	ANUARYI	2,2004
	6		30. Name and address of son who con Norberto M. Machira	npleted cause of death	(Item 23a) (Type,	Print) Choice In	n. Raltim			
	Str	ate	31. Date filed (Month, Day, Year)	32. Begistrar's		diotec III	Darein	,	,	
	Regist		IAN 1 5 200	4 America	. K A	asalis.				

			For State Registrer	State of	Maryland	-	artment of H tificate of L			ene2004	00779
	Physicia	an	Decedent's Name (First, Middle, L Table		mahath 1	Wa Ama	11		2. Date of Death Month Jan. 1	1 Day 2004 Year	3. Time of Death
	/Medic	al	4a. Fecility Name (If not institution, gr	eanor Eli		MCANA	4b. City, Town, or	Location of Dooth		4c. County of Death	6:45 a M
	Examin	er	139 Lassiter		0 1)		Finka			Carrol	1
	Funeral		5. Social Security Number 6.	Sex 7.	Age (In yrs. las	t birthday)	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. Birtho	lace (State or Foreign
	Director		220 05 2711	1□M 2∏F	91	Yrs.	Months Days	nouis Min.	Sept. 1		ryland
	and		Usuel Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation			1	0d. Inside City Limits
	Mary -f sho	tor	Md. Carroll	L		Fi	nksburg				1 ☐ Yes 2 🙀 No
	h the	irec	10e. Street and Number				10f. Zip Code		10	g. Citizen of What Cour	ntry?
	72 hours after death with the Maryland natural', or items 23a or 28e-f show dical Examiner must be notified at	Funeral Director	139 Lassite	er Circle			21048			U.S.A.	
	er dea	nuel	11. Marital Status	12. Was Decede Armed Force 1 \(\superset \text{Yes} \) 2	ent Ever in U.S.	13. \	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give		.	Yes 2√□ No	Specify:		Specify: Wh	ite
21215-0036	2 hou		15. Decedent's I			16a. Deced	lent's Usual Decupa kind of work done of	ition	king 1	6b. Kind of Business/Inc	dustry
2	ithin 7	Completed	(Specify only highest g	College (1-4	or 5+)	life. L	DO NOT use retired,)	\ing	Homemaker	
2	lied w tygier her th		10 17. Father's Name (First, Middle, Las			H	ousewife	18 Mother's Nam	e (First, Middle, M		
and	d be f	o Be	17.1 autors Name (1713), Nuculo, Las	.,	McDe	ermot	t		garet Doy		
Maryland	shoul nd Me r mark umeti	ဥ	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (Street a			City or Town, State, Zip	Code)
ž	and 2 alth a 27 is er trei		Jesse F. McAnal	ly III -	- Son	92 I	ndian Tra	il, Bris	tol, Conr	1. 06010	
Baltimore,	of He of He if item or oth		20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3	☐Removal from Sta	cem	etery, cren	sition (Name of natory or other place	a)		0c. Location - City or To	
Ë	tment tent: tent:		' 4 ☐ Donation 5 ☐ Other (Spec	ify)	Jan					kesville,	
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "natural; or Items 23a or 28e-f show any injury or other treumetic event, the Medical Examinational be notified at one.		21. Signature of Punerel Service Lice	hendt			Name and Addres Eckhardt 11605 Rei			P.A.	21117 . Md.
	Priysician /Medical Examiner	K	23a. Parti. Enter the disease, or co- shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate	a. Due to (or	as a consequer	DIAS	er the mode of dying	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
8760,	death certificate be executed e attending physician and id for use as the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or	as a consequer	nce of):					
.O. Box 6	the death certiff y the attending ached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		n 2 □ Fetal de It at time of deat	ath 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ory Day Year
rds, P	w requires that been signed b should be deta	þ	Part II. Other significant conditions	contributing to deat	h but not resulti	ng in the ur	nderlying cause give	n in Part I.	23e. Did toba	acco use contribute to th 2	e cause of death? ably 4 □Unknown
Vital Records,	The law ate has b page 2 s	Completed							24a. Was an autopsy perform 1 Yes 2	prior to con	osy findings available inpletion of cause of
Ĭξ	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othe	•	th (Check only one		
ō		5	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of	atient 2□EP	b. Time of	, and box	4 Divarsing in	ome 5 ⊿ Hesider 28d. Describe hov	ice 6 Other (Specify vinjury occurred	"
ion	Attending r death. sctor: After	atlor	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigati		Day Year)	Injury		? ′es 2 □ No			
Division	i Sitte	ertification:	3 Suicide 6 Could not determine	be 28e. Place of building	Injury - At home , etc. (Specify)	ə, farm, stre	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Rura State)	l Route Number,
	e Hospitel 24 hours a e Funerel I	edical C								use(s) and manner as state and place, and due to	
	To the H within 24 To the F complete	Medi	one) 29b. Signature and title of certifier	and manner	stated.		29c. License			d. Date signed (Month, I	
	Viti To Con		Huma	, Ku	les		70035	5398	23	1/14/04	,,
	10		30. Name and address of person who	1) 555	Douth	Cat	0 /	Water	rester	MD 21157	
	Sta Registr		31. Date filed (Month, Day, Year)	104 32. Heg	istrar's Signatur	4	Sparks				

-02	290		i icusc					•	Are Legible.	
			1 - For State Registrar	State of M		epartment of Certificate of			2004	00780
			Decedent's Name (First, Middle, La	ist)			200	2. Date of Dea	th	3. Time of Death
	Physici /Medio		Dallas		McCc	nnell		JANUARY	11, 2004	1332 P ^M
}	Examir		4a. Fecility Name (If not institution, given BAYVIEW HOSPITAL				or Location of Deat	th	4c. County of Death	
16	Funeral			Sex 7. Ag 1527M 2□ F	je (In yrs. last birtho 74 Yrs	Months Day			Year) 9. Birth	place (State or Foreign intry)
	Director		Usuel Residence of Decedent	Λ				NOV. 22	Viro	ginia
	anylan ehow	ž	10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Evarrans must be notified at ODEs.	Director	Maryland Baltimor 10e. Street and Number	:e	Essex	10f. Zip Code		1	0g. Citizen of What Cou	X
	23a ox	al Di	44 Berkshire Road	i		2	21221		USA	1
	r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Decedent of If Yes, specify Cu	Hispanic Origin? (Suban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Amen Black, White,	
36	irs afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 ☐ If Yes, Give Year or Dates:	No	1 ☐ Yes 2 📉 No			Specify:	ite
9	72 hou vatura ical E	ted	15. Decedent's E	ducation	16a. De	ecedent's Usual Occi ive kind of work don- e. DO NOT use retir	upation	and a install	16b. Kind of Business/Ir	
21215-0036	vithin no.	Completed	(Specify only highest gr.	College (1-4or	5+}			1	D 1 01	
	iled v Hygie ther t nt, th	S	17. Father's Name (First, Middle, Last	*)	Crai	ne Operato		me (First, Middle,	Eastern Sta	inless Corp
and	ntal hed of	Be		nnell				orothea	McConnel	1
Ë	hould d Me mark matic	J.	19a. Informant's Name/Relationship		19b M	ailing Address /Stree			r, City or Town, State, Zip	
Maryland	nd 2 s lith an 27 is i		Bettie Lou McConr	* * * * * * * * * * * * * * * * * * * *		Berkshire				o Code)
Baltimore,	s fai if Hea if Hea otha		20a. Method of Disposition			sposition (Name of crematory or other pl			20c. Location - City or To	own, State
Ë	Page nent c nt: If		1 ☐Burial 2 ☐Cremation 3 ☐ `4 ☐Donation 5 ☐Other (Speci					/14/04 B	alto. Co. M	arvland
aĦ	permit. Departmingortaile Importaile any inju		21. Sig ature of Funeral Service Lice	Mg00 //		22. Name and Add			ski Funeral	
8	89 = 8	l l	1-5			1407 old	Eastern A	Avenue Es	sex Marylan	d 21221
0.00	Pnysician /Medical		23a P rth Enter the disease, or come sock, or heart failure. Ust only Immediate Cause (Final dise or condition resulting in death)	a.	d the death. Do not ne. a consequence of):	enter the mode of a	ing, such as cardiad	. 0	Head	Approximate Interval Between Onset and Death
75,99	te be executed ysician and be burial-transit	cal Examiner	fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	a consequence of):					
687	a × a		•	_ d				<u> </u>		
.O. Box (The law requires that the death certificat to has been signed by the attending phy age 2 should be detached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 □Ectopic pregnant 5 □ Other (specify)	су		23d. Date of delive Month	ery Day Year
Δ.	res that the de igned by the a be detached f		Part II. Other significant conditions	contributing to death b	ut not resulting in th	e underlying cause g	iven in Part I.	23e. Did tot	pacco use contribute to the	he cause of death?
rds	w requires been sign should be	ed by						1 □ Y€	os 2 No 3 □ Prot	pably 4 Unknown
Records,	ne law re s has bee ge 2 sho	Completed		-4				24a. Was a		psy findings available mpletion of cause of
		Con						yes 2	ned? death2	2□ No
Vita	ystcian: This certificate director, pag	Be	25. Was case referred to medical examiner?	Marriant				ath C eck n on	θ	
	S S	2	1 Types 2 No	Hospital:		HOIL STADON			nce 6 □Other (Specif	y)
Division of	Attending Firdeath. sctor: After by the funer	atlon	27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio		y ear) 28b. Tim Inju	y Wa	ork? Yes 2/2/No	Sug (e file occurred	elf
DIVI		Certification;	3 Suicide 6 ☐ Could not be determined	building, et	c. (Specify)	street, factory, office		44 Brown	sofshire 1	40 21221
	To the Hospital or within 24 hours after To the Funaral Dircompletely filled in	edical	29a. Certifier 1 ☐ Certifying PI (Check only one) 1 ☐ Certifying PI 2 ☑ Medical Example 1	hysician: To the best miner: On the basis of and manner sta	f examination and/o	eath occurred at the I r investigation, in my	ime, date and place opinion, death occu	e, and due to the ca arred at the time, da	tuse(s) and manner as si ate and place, and due to	tated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title/of certifier	mD		1	ose number		9d. Date signed (Month, JANUARY 12,	
	1,1		30. Name and address of person who	completed cause of d			et. Baltin	more Mar	yland 21201	
3	Sta	1.59	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	Level is		one, indi	., 212VI	
	Registr	-146	18 N 1 5	. /H13# ■ #5#	62	Charles &				

	Amend Item#1, per Dr, G828, 2/11/2004, gap Certificate of D	ealth and Mental Hygiene 2004 0078
	Decedent's Name (First, Middle, Last) MAR.TORTE McMTLLIAN	2. Dete of Death 3. Time of Death
Physician	MARJORIE MUMILLAN	Month Day Year 0915
/Medical Examiner	4e Fecility Neme (If not institution, give street and number) 4b.	City, Town, or Locetion of Death 4c. County of Deeth
	Lorien Nursing Home	Columbia Howard
Funeral	Months Days	If Under 24 Hrs. B. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
Director	378-26-3230 90	January 15,13 Virginia
pue 🔭	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. fnside City Limits
Maryler f show	Maryland Howard Columbia	1 ☐ Yes 2 ☐ No
r 28a-f sho notified at	10e. Street end Number 10f. Zip Code	10g. Citizen of What Country?
23a or	6336 Cedar Lane 21044	USA
fter death with the Ma r items 23a or 28s-f s wher must be notified Funeral Director		panic Origin? (Specify Yes or No- , Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc.
· · · ·	1 Never Married 2 Married 1 Yes 2 No	Specify: Specify: White
"naturel", adical En		ion 16b. Kind of Business/Industry
	(Specify only highest grade completed) (Give kind of work done du life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+)	iring most of working
d within giene.	10 0 Clerk	Banking
be file tal Hys avent,	17. Father's Neme (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
should be filed within and Mental Hygiene. marked other than imatic event, the M	Robert Mann	Mary Terry
2 sho end la me		nd Number or Rurel Route Number, City or Town, State, Zip Code)
	1-1 -1 15 15 15 15 15 15	ourt, Baltimore, Maryland 21227
ges 1 if of H if Iter or oth	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 □ Burial 2 □ Cremation 3 □ Removal from State	Date 20c. Location - City or Town, State
Demit. Pages 1 end Department of Health Important: if Item 27 any Injury or other ti ange.	4 Donation 5 Other (Specify) Entombrent Loudon Park Cemet	tery 1/12/03 Baltimore, Maryland
permit. Pa Departmen Important: any Injury.	21. Jignature of Funeral Service Licensee 22. Name and Address	of Facility Hubbard Funeral Home, Inc.
20E # 3	4107 Wilkens I	Avenue, Baltimore, Maryland 21229
	23a. Part1. Erker the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line.	, such as cardiac or respiratory arrest, Approximate Interval Between
Physician		Onset and Death
/Medical Examiner	Immediate Cause (Final disease or condition	MENTIA
	resulting in death) Due to (or as a consequence of):	
executed in end iel-transit	b	
end end el-trar	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Undertying Cause (Disease or injury	
a program	cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es e consequence of):	1
를 찾을 등	resulting in death) Last Due to (or es e consequence of):	
teath certifice attending phase is the constant of the constan	d	
d for d	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given	n in Part I. 23b. Did tobecco use contribute to the cause of death
es that the death certific igned by the attending p be deteched for use es by Physician/Mec	Part II. Other significant containous containoung to death out not resulting in the underlying cause given	1 Yes 2 No 3 Probably 4 Unknow
± 00 ~		
v requires been sign should be		24a. Was an autopsy performed? 24b. Were autopsy findings available prior to
0 0		completion of cause of death?
The law ete has pege 2		1 Vos 2 No 1 Yes 2 No
certificate rector, per	25. Was case referred to medical	26. Place of Death (Check only one)
	examiner? 1 Yes 2 No	Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
g Physer this seral di	27. Menner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of linjury Work?	
Attending F r death. ector: After by the funer filcation:	2 Accident investigation M 1 Ye	es 2□No
Ital or Attending P ins efter death. all Director: After t led in by the funera Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f, Location (Street and Number or Rural Route Number, City or Town, State)
s and a separate of a separate		
ne Hospi n 24 hou ne Funer pletely fill edicai	29a. Certifier (Check on) 1 ✓ Certifying Physician: To the best of my knowledge, death occurred et the time 2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opin	
To the Hospital or Attendit within 24 hours after death. To the Funeral Director: At completely filled in by the fu	on(e) and manner stated.	
Within To the	29b. Signature end title of certifier 29c. License	
V	Jan Breeze > MD 15006	50560 JANUARY 69, 2004
· ·	30. Neme end eddrest of person who gompleted cause of death (Item 23e) (Type, Print) PANKAT KHETER PAL 201-109 BACK RI	IVER NECK RD. BALTMORE, MD
State		
Registrar	31. Date filed (Month, Day, Year) JAN 1 5 2004 32. Registrer's Signeture	
IMH 16 Rev 6/95	place to beach	

			1- For State of Marylan			Health a		il Hygie	ene 200	4 00	782
	Physic	ian	Decedent's Name (First, Middle, Last)				_ Mo		Day Yea		
P	/Medi	cal	Betty Jane Molesworth 4a. Fecility Name (If not institution, give street and number)		th City Town	and annula a se	Jan	•	11 2004		э м
	Examir	ner			4b. City, Town,		r Death		4c. County of De		
	Funeral		Manor Care Towson 5. Social Security Number 6. Sex 7. Age (in yrs.	last birthday)	If Under 1 Yea			e of Birth	Baltimor	e inhplace (State or Country)	Foreign
í.	Director		032-07-7719 1 N 2 F 84	Yrs.	Months Days	Hours		nth, Dey, Y	1919 M	D D	
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City	y, Town or Lo	cation					10d. Inside City	v Limits
	Mary I-f eh	to	MD Baltimore	Towson	1					1 □ Yes 2	
	th the	lrec	10e. Street and Number		10f. Zip Code			10g	. Citizen of What 0		
	ath w	ral	509 E. Joppa Rd.			21286			USA		
980	hours after death with the Maryland turel , or items 23a or 28a-f show al Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U. Armed Forces? 1 Yes, Give	li li	Was Decedent of f Yes, specify Cul 1 ☐ Yes 2√7 No		in? (Specify Ye Puerto Rican, o	s or No- etc.)	14. Race - An Black, Wh Specify:		
5-0	72 hours af "naturel", or alical Exam	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decec	ient's Usual Occu	pation	of working	16	b. Kind of Busines	s/Industry	
21	d within jiene. r then "	mple	Elementary/Secondary (0-12) College (1-4or 5+)	life. L	DO NOT use retir	ed)	or working				
2	D .C. =	CO	12 n/a	Ho	memaker		's Name (First,	44:22: 44:	Own F	lome	
Maryland 21215-0036	be data	o Be	Perry R. Knight				rian We		iden Sumamej		
ary	d 2 should Ith and Meni	۲	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Stree	1			ity or Town, State,	Zip Code)	
	and 2 Baith a n 27 i		Susan Tearle/daughter	7903	Shore	Rd., E	3alto.,	MD 2	1222		
Baltimore,	Pages 1 and ment of Heatt ant: If Item 2 ary or other		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	emetery, crem	sition (Name of natory or other pla	· .	Date 1/15/04 al Garde		c. Location - City o		03
Balt	permit. Pag Department Important: I any injury o		21. Signature of Emeral Septembriese Michael Flagle	22	. Name and Addr	ess of Facility			laney √a ım, MD 2		
	Physician /Medical Examiner	niner	23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	uence of):	er the mode of dy	ing, such as c	ardiac or respire	atory arrest		Approximate Interval Betwe Onset and De	een
8760,	cate be executed physician and the burial-transit	ical Examiner	that initiated events resulting in death) Last c. Due to (or as a consequence of the con	ence of);							
Вох 68	ath certifi ittending or use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ ∀es 2 ☑ No 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal	death 3	Ectopic pregnanc	ey .			23d. Date of de Month	elivery Day Yea	ar *
P.O.	t the c by the tached	hysi	9 Unknown		(4,200.1)/_						
Records, F	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions contributing to death but not resu	iting in the un	derlying cause gr	ven in Part I.	236	. Did tobac	co use contribute t	o the cause of dear	
	a: The law icate has b	Completed		-			_	. Was an autopsy performed Yes 201	prior to death?	utopsy findings ava completion of caus s 2 No	ailable se of
<u> </u>	siciar certif recto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ E	- D/O	-0 -0. 0#	/	of Death (Check	*			
o	g Phy er this eral d	n: To	27. Manyler of Death 28a. Date of Injury	28b. Time of	28c. Inju	ry at			e 6 ☐Other (Spe	icity)	
ion	ath. r: Afte	atlo	1 XNatural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury	Wo	rk?]Yes 2.∭Q√0	,	0	NA.		
Division of Vital	tal or Atters after de safter de al Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, stre	et, factory, office		28f. Loca City	ition (Street or Town, St	t and Number or Ritate)	ural Route Number	r,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director; After this certificate ha completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examinate and manner stated.	rledge, death on and/or invi	occurred at the ti estigation, in my	me, date and opinion, death	place, and due occurred at the	to the cause time, date	e s) and manner as and place, and due	s stated. to the cause(s)	
	with To con	Σ	29b. Signature and letter of certifier	w	29c. Licens	se number	3/ /	29d.	Date signed (Mont	h, Day, Year)	
	5		30. Name and address of person who completed cause of death (Item	23а) (Туре, Р	rint) / EF	4/2	Fishe	RI	UN	7.0	
	Sta	9	31. Date filed (Month, Day, Year) 32. Registrar's Signatu	2 50 ure	ne.	3//	TOWS	-ON	MS	x1204	
	Sta Registra				. Ma						
DHA	/IH 17 Rev 1/20	01	JAN 1 5 2004	1	A CONTRACTOR						

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00783 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Lest) Month Year Physician OPM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Neme (If, not institution, give street end number) Examiner allon astor HOSPICE avoitabrius If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Months 1 4M 2 F 32 974 66 Yrs. 24 Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after deeth with the Marylend Department of Health and Mantal Hyglena. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at another. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State lalbot 1 Yes 2 1 No M.D **Funeral Director** FASTO 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number UoSo 21601 586 N Wood 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Yeer or Dates: 0 4 6A Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Maritel Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1□ Yes 2☑No à White 3 Widowed 4 Detvorced DYEARS Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 years Coverner EN FORCEMENT 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Be ber Otis MAThews MARIAN Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 940 21075 EIKKID LE MD Gordon 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State indel Crema ton 15/04 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name end Address of Facility 23a. Parti Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. 7516 Cornelly for HANDE MP 21076 Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Differient ated Examiner Due to (or es a consequence of) The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of) Part II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Hospital or Attending Physician: The law 24 hours after death.
Funeral Director: After this certificate has it 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 DOther (Specify) 1405 pice 1 ☐ Yes 2 € No 3□ DOA Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check only one) 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature end title of certifier 2004 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 509 IDEWOLD RD EASTON MO 21601 hiElds

Registrar

State

2004 32. Registrer's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

D		1. For Unpend Item #	State of Mar 23a&27 per	yland/De me G826	epartmen Be <i>Hill</i>	t of Hea 9⁴of 4 9€	alth and N Bath		giene Reg. No.	2004	00	784
Physici		1. Decedent's Name (First, Middle, Last, Glenn Barry Moral						2. Date of Dea Month Januar	Day	Year 2004	3. Time of 0634	
/Medic Examin		4a. Facility Name (If not institution, give 5706 Carrington D:				Town, or Loc emarsh	cation of Death		4c.	County of Deeth		
Funeral Director		212-30-3723	x DM 2□F	In yrs. last birtho	Months		Under 24 Hrs. Hours Min.	8. Date of Birt 12/22/1	950	9. Birthi Cou	olace (State o ntry)	r Foreign
show	j	Usual Residence of Decedent 10a. State 10b. County MD Baltimo:		10c. City, Town o		e Mars	sh				10d. Inside Ci 1 ☐ Yes	•
a or 28a-f	Direct	10e. Street and Number 5706 Carrington D	rive		10f. Zip	Code 1162	,		10g. Citiz	zen of What Cou	ntry?	
I, or items 23	by Funeral Director	11. Marital Status 1 □ Never Married 25 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 € No If Yes, Give Year or Dates:		13. Was Dece	dent of Hispa city Cuban, N	nic Origin? (Sp Mexican, Puerto Specify:	pecify Yes or No- Dican, etc.)	-	14. Race - Ameri Black, White, Specify: Wh:	etc.	
penint. Tages I and Stoom between the many and penint. Tages I and Stoom between the many and penint. It leads and Mental Hydere. Inportant: If leads 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examine Frust by notified at ORGE.	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation	(0	ecedent's Usu. Give kind of wo ife. DO NOT u	rk done durii se retired)	ng most of worl	king	Ir	on Worke al 16 S	-	
lo be mediental Hygic ked other ic event, ii	To Be Co	17. Father's Name (First, Middle, Last) James A. Morales			TIOIT W		. Mother's Nam	ne (First, Middle, DeNevi	Maiden	Sumame)		
alth and M	-	19a. Informant's Name/Relationship (7) Nancy Morales	_{vpe, Print)} Wife					ral Route Numbe		Town, State, Zij . 21128	Code)	
nent of He ant: If Item ary or othe		20a. Method of Disposition 1 □ Burial 2 【② Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		20b. Place of D cemetery, Metro (crematory or c	ther place)		Date		cation - City or To nsville		
Departr Departr Imports eny inj		21. Signature of Frm VI Se vice Licens	99		22. Name ar 1211 Ch		Avenue	ach/Rose Rosedal	edale le Ma	e Funera aryland	1 Home 21237	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 burous after death. To the Funaral Director: After this certificate has been signed by the attending physician and unique properties in by the funeral director, page 2 should be detached for use as the burial-transit are burial-transit.	dical Examiner	if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	clerotic consequence of) consequence of) consequence of)):	ovascu	ılar dis	sease		- 11	- W	
the death certification of the attending phoched for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown	☐ Fetal death	3 Ectopic p 5 Other (sp				2	23d. Date of deliv Month		Year
w requires inat ine of been signed by the should be detached	by	Part II. Other significant conditions co	ntributing to death but	not resulting in t	he underlying o	ause given i	n Part I.	23e. Did to		se contribute to t	he cause of d	
Ine taw recated the sate has been page 2 short	Completed							24a. Was autop perfo 1 X Yes	med?	24b. Were auto prior to co death? 1 (X) Yes	opsy findings impletion of c 2 No	available ause of
uning ritystelen: In h. After this certificate funeral director, pag	tion: To Be	25. Was case referred to medical examiner? 1 XYes 2 No 27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day	28b. Tin	ne of	Other: 28c. Injury at Work?		th (Check only of ome 5 Residence 1986). Describe h	lence 6	Other (Special occurred)	_(y) At	Scene
To the hospital of Atlanting is within 24 hours after death. To the Funaral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.		n, street, factor	y, office		28f. Location (S City or Tox		d Number or Run)	al Route Num	iber,
ne Hospir n 24 hours ne Funara oletely fille	ledical (rsicien: To the best of iner: On the basis of e and manner state	examination and/								;)
within To the	2	29b. Signature and title of certifier	Heerbe	ng M.	D	O.C.N				e signed (Month, lary 13,	-	
St	ate	31. Date filed (Month, Day, Year)	ompleted cause of deal of the Volume of the	M.U.	ype, III I	Spore		Baltimon	æ, M	Maryland	21201	

		•	For State Registrar	State of Mary		artment of He rtificate of D		Reg.	2011	4 00785			
r	Physici /Medic		Decedent's Name (First, Middle, Last, Broadus W.		erritt	Sr.		2. Date of Death Month January	Pay 2004				
*	Examin		4a. Facility Name (If not institution, give Chesapeake Hospi 5. Social Security Number 6. Sec	ce House	n yrs. last birthday)	4b. City, Town, or Lint	Location of Death hicum If Under 24 Hrs.	8. Date of Birth		nne Arundel			
	Funeral Director			M 2□F	80 Yrs.	Months Days	Hours Min.	March 25	1923	irthplece (Stete or Foreign Sountry) NC			
	Maryland a-f ehow	tor	10a. State 10b. County Maryland Anne Ar		c. City, Town or Lo		Burnie			10d. Inside City Limits 1 ☐ Yes 2 ☑ No			
	th with the 23s or 28s	al Director	10e. Street and Number 923 Andrews Road			10f. Zip Code 2106			Citizen of What C	Country?			
036	d within 72 hours after death with the Maryland plene. Ir than "naturel", or Itema 23a or 28a-f ehow the Medical Evaninet roual be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2☑ No	spanic Origin? (Sp , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:				
9500-5121	within 72 ene. than "na he Mcdic	Completed	15. Decedent's Edu (Specify only highest grad	cation (e completed) Coltege (1-4or 5+)	(Give	dent's Usual Occupat kind of work done du DO NOT use retired)	Hauling	ind of Business/Industry					
land 2	ould be filed Mental Hygi arked other atic event,	To Be Co	17. Father's Name (First, Middle, Last) Almond Dawoo	od	Merritt		18. Mother's Nam Rettie	e (First, Middle, Mai		Parker			
Z Z	nd 2 shallth and 27 is m		19a. Informant's Name/Relationship (T) Janice Rumenap	ity or Town, State, Park MD	F /								
Baitimore,	permit. Pages 1 a Department of Hes Important: If item any injury or othe		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Removal from State	Glen Have	sition (Name of matory or other place, en Cemeter	y 1/16/	04 G		ie Maryland			
Ва	permit Depart Impor any in		21. Signature of Funeral Service Xirens	81.	3	Name and Address	ain Road		, MD 211				
	Physician /Medical		23a. Part . Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a	arce	er the mode or dying,	Te squ	1 C		Interval Between Onset and Death			
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Examiner	ner	Sequentially list conditions, if any, leading to minediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a consequence of): Due to (or as a consequence of).									
68760,	eath certificate be executed attending physician and for use as the burial-transit	edicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of):								
C. Box	D a D	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delivery Month Day				
ecords, P	law requires that the de as been signed by the 2 should be detached	by	Part II. Other significant conditions co	ntributing to death but no	ot resulting in the u	nderlying cause giver	n in Part I.		tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown				
r	The la ate has page 2	Completed						24a. Was an autopsy performed 1 ☐ Yes 2 ☑	prior to completion of cause of death?				
<u>.</u>	ding Phys n. After this funeral dii	atlon; To Be	27. Manner of Death Natural 5 Pending 2 Accident Investigation	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatien 28b. Time of Injury	ot 3 DOA Other	4 Nursing Ho	h (Check only one) ome 5 Residence 28d. Describe how i	esupode earth as grapho is a				
Division		Certification:	3 Suicide 6 Could not be 4 Homicide determined	At home, farm, str Specify)	eet, factory, office		28f. Location (Stree City or Town, S	itreet and Number or Rural Route Number, m, State)					
1	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical		sician: To the best of m iner: On the basis of exa and manner stated	amination and/or in-		nion, death occur	red at the time, date		e to the cause(s)			
)	Z.H		30. Name and address of person who co		(ltom 23a) (Type	- 03	1551			12,2004			
) '	te.	31. Date filed (Month, Day, Year)	CLuce (100 32. Registrar's	3051	Mospik	1 Din	= 16/en8	Sum, Mu	1-2106			
	Registr		IAN	1 5 2004 A	Weeks L	F GODALL							

				State of Ma	aryland .		rtment of tificate of		mental Hy	rgiene Reg. No. 2 (104	00786			
			1. Decedent's Name (First, Middle, Lest)						2. Date of Death Month Day Year 3. Time of					
	Physici /Medic		Mar	garet D	. Nels			Janua		6:25PM					
	Examin		4a Fecility Neme (If not institution, give	street end number)	Location of Dee	th 4c. County	of Death								
			Carriage Hill Nurs	ing Home				Bethesda		Mont	gomer	У			
	Funeral		Social Security Number 6. Security Number		e (In yrs. last		if Under 1 Yea Months Days			rth ay, Year)	9. Birthpl	ace (State or Foreign			
	Director		309-44-4304]M 2∏ F	92	Yrs.			Aug. 7	, 1911		onsin			
	pue }		Usuel Residence of Decedent 10a. State 10b. County		10	Od. Inside City Limits									
	fanyt	5			10c. City, T							1 ☐ Yes 2 ☑ No			
	28a-	Director	Maryland Montgomery Bethesda 106. Street end Number 109. Citizen of What Co												
	M M														
	heath re 23	era	5215 W. Cedar Lane		Specify Yes or N		e - America								
21215-0020	s 1 end 2 should be filed within 72 hours after death with the Marylend of Health end Mentel Hyglene. Item 27 is marked other than "natural", or items 23s or 28s-4 show other traumatic event, the Medical Examiner must be notified at	by Funeral	1 Never Married 2 Married 3 ☑ Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give X Year or Dates:	No X 1 Yes 2 No Specify:				rto Rican, etc.)		_{cify:} White				
Õ	2 ho	Completed by	15. Decedent's Edu	cation	tion 16e. Decedent's Usual Occupation					16b. Kind of B	Business/Industry				
7	thin 7	g	(Specify only highest gred	e com <i>pietea)</i> College (1-4or 5	i+)	life. D	O NOT use retin	during most of we	orking						
7	od wi	Š		4			Homemal	cer		Но	me				
P	of H	Be (17. Father's Neme (First, Middle, Last)					18. Mother's Na	ame (First, Middle	, Maiden Surnan	10)				
yla	Ment Ment arked attc	٥	Arthur Davidson	iesel_											
lar	12 should be filed within h end Mentel Hyglene. Fis marked other than " fraumatic event, the Mes		19e. Informant's Name/Relationship (Ty	rpe, Print)	1	19b. Mailing	Address (Stree	t and Number or F	Rurel Route Numb	er, City or Town,	State, Zip	Code)			
2,	1 end 3 Health em 27 l		Richard D. Nelson/Son 5902 Harwick Road; Bethesda, MD 20816 20a. Method of Disposition 1 Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State												
0															
Baltimore, Maryland	permit. Pages 1 end Depertment of Health Importent: if item 27 any Injury or other to		4 Donelion 5 Other (Specify) Loudon Park Crematory 1/15/04 Baltimore, MD 21. Sign re of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute Funeral and Cremation Center												
Ba	Deper Deper Impor any Ir														
	00260	_	1040 Rockville Pike; Rockville, MD 20852												
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caused ne cause on each lir	the death. [Do not enter	r the mode of dy	ing, such as cardia	c or respiratory a	rrest,		Approximate Interval Between			
	Physician /Medical		Immediate Cause (Final									Onset and Death			
	Examiner		disease or condition resulting in death)	a. <u>Dement</u>											
	_ '	ē	Due to (or es a consequence of):												
	ifficate be executed g physicien end es the buriel-trensit	Examiner	Hypertension Due to (or as a consequence of):												
ó	exec an en riel-tr	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events												
68760,	flicate be executed g physicien end es the buriel-trensit	edicai	Cause (Disease or injury that initiated events resulting in death) Last	÷	Due to (or as	a conseque	ence of):	, ,							
			Testiting III deatily Last												
Вох	eath cert ettending I for use e	Physician/M	<u> </u>								1	-			
	it tha dea by the et stached fo	Sic	Part II. Other significant conditions con	iven in Part I.	23b. Did	23b. Did tobacco use contribute to the caus									
P.0	d by I		Dysphagia		<i>j</i> -				1 🗆	1 ☐ Yes 2 ☒ No 3 ☐ Probably 4					
Š	requiras that tha death certean signed by the ettendininould be detached for use	à	рубриадіч												
0	v require bean si should	Completed							24a. Wes	an autopsy ormed?	ava	re autopsy findings ilable prior to ipletion of cause			
360	The lew ata has b page 2 s	ğ									of d	eeth?			
<u>a</u>	: The cata h								1 🗆	Yes ANO	10	Yes 2□ No			
of Vital Records,	Physician: The this certificata rel director, pag	Be	25. Was case referred to medical examiner?	lospitel:			OI	hor:	eath (Check only						
ō	Phys this rel di	ဥ	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpatie		Outpatient b. Time of	3LI DUA	4 LA Nursing	Home 5 Resi)			
o	ding f h. After funer	tion	1 Natural 5 ☐ Pending investigation	(Month, De)	Year)	Injury	28c. Inju Wo M 1	ork?]Yes 2 □ No	28d. Describe how injury occurred						
Division	Attending is deeth. ector: After by the funer	Eg	3 Suicide 6 Could not be	28e. Plece of Inju	ry - At home	, farm, stree	et, factory, office		28f. Location (Street and Numb	er or Rural	Route Number,			
ă	afte safte	Certification:	4 Homicide	building, etc	:. (Specify)				City or To	wn, Stete)					
/	Hospi 4 hou Funer aly fill	edlcai	29a. Certifier (Check only 2 Medical Examin	ner: On the basis of	examination	dge, death of end/or inve	occurred at the t	me, date and plec opinion, death occ	e, and due to the urred at the time,	cause(s) and ma date and place.	nner as sta	ited. the cause(s)			
and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signature											(Month, D	av. Yeer)			
										-					
	10	-	30. Name end eddress of person who co	Anloted source of d	noth /lton on	a) /Tunn P	D355	/9		January	y 13,	2004			
	IV		Susan J. Miller, M					Bethesd	a. MD 20	816					
	Stat	e	31. Date filed (Month, Day, Year)		er's Somature			p promote a	a, mb 20	010					
	Registra	54		200	100	1	Mary	81							

DHMH 16 Rev 6/95

			For State Ragistrar		State o	f Marylan	-	artment o					gien Reg. N	/ 1111	and the second	00787
	Physicia		1. Decedent's Name (First, M Catherine Le									2. Date of De Month	Da	200		3. Time of Death
0	/Medic Examin		4a. Facility Name (If not institu	ition, give		mber)		4b. City To	wn, or	Location			40	c. County of D	eath	
	Funeral		5. Social Security Number	6. S	M 2SF	7. Age (In yrs.	last birthday) Yrs.	If Under 1 \ Months D	Year Days	If Under Hours		8. Date of Bir (Month, Da 10/31/	y, Year	9.		ace (State or Foreign try)
	Director		216-05-1233 Usual Residence of Deceden			93	ty, Town or Lo					10/31/	1910			0d. Inside City Limits
	Maryland I-f show	tor	MD Ba1	nty Eimo:	ro	Toc. Cil		nsvill	0							1 ☐ Yes 2 🛣 No
	death with the ms 23a or 28a roust be noti	Funeral Director	10e. Street and Number	C IniO				10f. Zip Co	ode				-	itizen of What	Coun	try?
	death v ms 23e	neral	119 Rosewood .	Ave.	12. Was Dec	edent Ever in U	.S. 13.	Was Deceden		21228 spanic Ori		ecify Yes or No Rican, etc.)		JSA 14. Race - A		
36	ē 2 E	by Fur	1 Never Married 2 3		Armed Fo 1 ☐ Yes If Yes, Gi Year or D	2 ⊠ No ve		ir res, specify 1 ☐ Yes 2 🖫				rican, etc.)		Black, W Specify:		nite
5-00	within 72 hours after ene. then "neturel", or ite he Medical Examilia		15. Dece (Specify only hi	dent's Ed	lucation		(Give	dent's Usual C	done di	urina mos	t of work	ing	16b. I	Kind of Busine		
2121	filed within Hygiene. wher then "	Completed	Elementary/Secondary (0-1	2)	College (1-4or 5+)		<i>DO NOT use i</i> maker	retirea)				Pei	csonal	Res	sidence
Maryland 21215-0036	should be filed within and Mental Hygiene. marked other than marked other than marked other than matic event, the Mental contents and the Mental conte	Be	17. Father's Name (First, Mid							18. Moth		e (First, Middle				
arvis	d 2 should th and Men 7 is marke traumatic	은	John W. Masti 19a. Informant's Name/Relat		Type, Print)		19b. Maili	ng Address (S	Street a	nd Numbi		nes Lil al Route Numb				Code)
≥	1 and 2 Health a tem 27 is		Thomas R. Nel	son/	Son	20b. F	Place of Dispo	OSEWOO	of	1		timore,		21228 Location - City	or To	wn. State
altimore.	Pages nent of H int: If Ite		1 Burial 2 Cremat 4 Donation 5 Other			State	cemetery, crei	matory or othe h-Crem	er place					aurel.		
Balti	permit. Pages 1 and Department of Health Importent: If Item 27 eny injury or other tr		21. Signature of Funeral Sen	vice Lice	600		2; W		Addres: Fun	s of Facili eral	ty Home	e of ca	tons		Iı	nc. 1228
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List of a one cause on each line. Approximate Interval Between Onset and Death												Approximate Interval Between	
	Physician /Medical		disease or condition resulting in death)		a Due to	(or as a consec	quence of):	in							+	week
	Examiner	er	Sequentially list conditions, if any, leading to immediate	J	b. Due to	(or as a consec	quence of):									
K	be executed sician and burial-transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	quence of):												
.0928	The state of the s	cal		l	_ d											
11/JE	death cert e attendin id for use	Physician/Med		23b. Was decedent pregnant in the past 12 months? 1 Yes 2 MNo 1										23d. Date of Month		ory Day Year
#6K		b S	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								I.	23e. Did tobacco use contribute to the cause of de				
NELSON . CATH	The law requir ate has been si page 2 should	Completed												prior deat	to cor	psy findings available inpletion of cause of
Siz	icien: certifica rector, p	Be	25. Was case referred to medical examiner? Hospital: Other Check only one)													
357	ing Phys	lon: To	1 Inpatient 2 EHOutpatient 3 DOA 4 Nursing Home 5 Hesidence 6 Date (Specify)										9			
JUE.	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	2 Accident 3 Suicide 4 Homicide N 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Formation City or Town, State)								<i>R</i> ura	l Route Number,				
	Hospital 24 hours Funeral itely filled	edical Co			miner: On the I	e best of my kn basis of examin										
	To the within To the comple	Mec	29b. Signature and title of ce	rifier 1	~ MD					number				rate signed (M		0ay, Year) 1 200 Y
	50		30. Name and address of pe	son who	completed cau	use of death (Ite	m 23a) (Type,	Print) R	n.lt	Timos	-e_ /	Marylo	ind	2)		
		ate	31. Date filed (Month, Day,	'ear)	32.	Registrar's Sign		20 1	Car	es :	J	*				•
	Regist	ıaı		UN	11 7 4 2	Pour	- Charles	- 17	-							

		-	For State Registrar	State of I	Maryland		artmen rtificate			and M		giene	1111	100	00	788		
	Physicia	an	1. Decedent's Name (First, Middle, Las								2. Date of De Month	Day	/ Y	'ear	3. Time			
	/Medic	al		r, Sr.						(5. 0	JAN	12		00K	6	IDAM		
	Examin	er	4a. Facility Name (If not institution, give						Location o			40.	County of	n/a				
	F				Age (In yrs. I	ast birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Bir	rth ,	9			or Foreign		
	Funeral Director		215-03-7189	3X X M 2□ F	87	Yrs.	Months	Days	Hours	Min.	(Month, Da Sept.	ау, Үө <i>аг)</i> 14 , 1	916	Ma	ry) rylar	nd		
	p ,		Usual Residence of Decedent		100 Cib	. Tour or Lo	oation							10	Od Incide	City Limits		
	with the Marylan a or 28a-1 show Le notified at	5	10a. State 10b. County 10c. City, Town or Location Maryland n/a Baltimore											1 ☑ Yes 2 ☐ No				
	28a-f	ect	10e. Street and Number 10f. Zip Code 10g.										Citizen of What Country?					
	3a or	Funeral Director	2102 Walshire Avenue 21214 Unit										nited	ited States				
	death	nera	11. Marital Status	S. 13.	Was Deced	lent of Hi	spanic Orig	gin? (Spe	cify Yes or No Rican, etc.)	0-	14. Race -	America White, e						
9	or Ite	교	1 ☐ Never Married 2 ☐ Married	1 Nes 2 No			1 ☐ Yes 2		Specify:	.,	, , ,		Specify:					
21215-0036	filed within 72 hours after death with the Maryland Hygiene. Hygiene. Inter then "natural", or Items 23s or 28s-f show ent, the Medical Exertin or Innat Le Incilling and	pd by	3 X Widowed 4 ☐ Divorced 15. Decedent's Ed		es: WWII		dent's Usua	I Occupa	ation			16h Ki	ind of Busi			•		
5	in 72	plete	(Specify only highest gra	de completed)		(Give	kind of wor DO NOT us	rk done d se retired	during most	t of workir	ng				,			
212	d with giene.	Completed	Elementary/Secondary (0-12) 8 yrs.	College (1-4	or 5+)	Dr	river	/ Sa	alesm	an		Ame	<u>erica</u>	n Br	ewery	y		
ם	be filed watal Hygier of other ti	Be	17. Father's Name (First, Middle, Last) James Nocar							r's Name eres	(First, Middle	, <i>Maiden</i> nenda						
Maryland	D 7 2 0	၉						(0)						-1- 7'-	0-4-1			
Mar	0 2 0		19a. Informant's Name/Relationship (3 Mr. Louis J. Noca	* *	Son		ng Address 3 Haro				<i>I Route Numb</i> Baltimo					214		
	ges 1 and t of Health ff item 27 or other to		20a. Method of Disposition	, 0, ,	20b. P	lace of Dispo	sition (Nan	ne of	1		ate	_	cation - C			-1-1		
ğ	00		1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify			emetery, crei 'KWOOd				1/15	/2004	Balt	imor	e. M	larvla	and		
Baltimore,	permit. Page Department Importent: fl any injury o		21. Signature of Funeral Service Licen	·		app 22	2. Name an	d Addres	s of Facilit	у	53	305 F	larfo	rd R				
ñ	Per Per Per Per Per Per Per Per Per Per) Willey	/-			Leonar	d J	. Ruc	k, I	nc. Ba	altin	nore,	MD	2121	14		
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. PNE	in line.	VIA	ter the mod	e of dying	g, such as	cardiac o	r respiratory a	arrest,			Approximation Interval Bookset and	etween		
[3	iate be executed XX	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. CON Due to (or c.	as a consequence as a c	TIVE	HE	A£	27 F	FAIL	URE							
.O. Box 6	res that the death certific igned by the attending p be detached for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown										f delivery Day Year				
ď.	is that gned b e deta	by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did	tobacco u	co use contribute to the cause of death?					
ğ	w require been sig should b	led l	COLON CANCER, CHRONIC OBSTRUCTIVE 10 Yes									Yes 2	2 No 3 Probably 4 Unknown					
Division of Vital Records,	The law r cate has be page 2 sh	Completed	_PULMONARY !	DISEASE, HTPER LIPIDEMIA							24a. Was auto perfo 1 □ Yes		or to con ath?	re autopsy findings available r to completion of cause of th? Yes 2 XNo				
Vita	sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence														
ō	Phys r this ral dii	. To	1 Yes 2 No 27. Manner of Death	28a. Date of	Injury	ER/Outpatier 28b. Time o		Bc. Injury Work	4 🗆 🖂 🗆	4 Nutsing Home 3 Residence 6 Other (Specify)								
on	ding th. : After	tlon	1 Natural 5 Pending 2 Accident investigation	(Month,	Day Year)	Injury	м	Work 1 □ `	k? Yes 2 🔲 I	No								
Divisi	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							2	28f. Location (Street and Number or Rural Route Number City or Town, State)							
1	he Hospit in 24 hours he Funere pletely fille	Medical (29a. Certifier (Check only one)	y sician : To the b niner: On the bas and manne	is of examinat	wledge, deat tion and/or in	vestigation	, in my op	pinion, dea	d place, a	and due to the ed at the time,	, date and	l place, an	d due to	the cause			
V	To t To t	Σ	29b. Signature and title of certifier M. Kolloum	MA					e number	`		39d. Dat	e signed (
									2000			071	12	ر ا	2004			
	10		30. Name and address of person who	completed cause	of death (Item	1 23a) (Type,	Print) Mi	HEL		+ KU	MORE	MN	4172	0				
	Sta	te.	GCOD SAKARIT AN 1 31. Date filed (Month, Day, Year)	32. Reg	5601 L gistrar's Signa	ture	AVENI	JLV1	- DF	1111	TUKE	1117	JUIN S					
	Registi		IAN 1 5 200		14	Rose	0											

100		State Registrar 1. Decedent's Name (First, Middle,	Last)		Ce	rtificate of L	veath	2. Date of D	Reg. No).	3. Time of Dea
icia				terso	n			Month	Da		
dica nine		4a. Facility Name (If not institution,			11	4b. City, Town, or	Location of Deal			County of D	
		GOOD SAMAR	RITAN HO	SPITI	AL	BALTI	MORE				
al		,	5. Sex 7. A 1 □ M 2 🔏 F	ige (In yrs.	last birthday)	Il Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, D	irth ay, Year,	9.	Birthplace (State or For Country)
or	-	212-22-4969 Usual Residence of Decedent	10 M 2031	_80	Yrs.			1/11/1	924		est Virgini
		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					10d. Inside City Lin
	ţo	Maryland Baltin	ore	Fas	tpoint						1 ☐ Yes 2X
	Funeral Director	10e. Street and Number			<u></u>	10f. Zip Code			10g. Ci	tizen of What	Country?
:	la	8011 Eastdale Ro	oad			21224			U.	S. A.	
	nue	11. Marital Status	12. Was Deceder Armed Forces	?	.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (S n, Mexican, Puer	Specify Yes or N to Rican, etc.)	0-		merican Indian, hite, etc.
1	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 X If Yes, Give Year or Dates			1 ☐ Yes 2X No	Specify:		- 1	Specify:	T = 1 . 1
:	pa	15. Decedent's		•	16a. Dece	dent's Usual Occupa	tion		16b K	(ind of Busine	White ss/Industry
	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-40)	(5.1)	(Give	kind of work done di DO NOT use retired)	uring most of wo	rking	100.11		ou modelly
	E C	Lietheritary/Secondary (0°12)	2	3+)	Homen	aker			Own	n Home	
	Be (17. Father's Name (First, Middle, La	ast)				18. Mother's Na	me (First, Middle	e, Maiden	Sumame)	
	၉	John Pennington					Anna Ad	damson			
ľ		19a. Informant's Name/Relationshi			1	ng Address (Street a			_		
	1	Becky Lurz (Daug	ghter)	look D	7829	St. Grego	ry Drive			_	
		20a. Method of Disposition X Burial 2 □ Cremation 3	B □Removal from Stat		emetery, crer	sition (Name of matory or other place	1	Date / 1 4	20c. L	ocation - City	or Town, State
l	1	`4 □Donation 5 □Other (Spe		Но		ll Mem. G	ard. 20	004	Bal	timore	, Maryland
		21. Signature of Funeral Service Li	censee		Br	Name and Address UZdzinski	Funera	l Home I	PA		
	\dashv	230 Part Fotor the disease or o	of officer	5mg						, Mary	land 21221
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresphace, or heart failure. List only one cause on each line.									Approximate Interval Between Onset and Death
l		Immediate Cause (Final disease or condition resulting in death) a. SEPSIS Due to (or as a consequence of):									
ı						ACT II	ICECT	101			
	ē	Secuentially list conditions if any, leading to immediate	Due to (or a			JTC1 11	41661	ION			
1	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	6 =====								
		resulting in death) Last	Due to (or a	s a consequ	uence of):						
	cal		d								
	Physician/Medic	IF FEMALE:									
	an	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1□Live birth	2 Fetal	death 3	Ectopic pregnancy				23d. Date of o Month	delivery Day Year
1	SIC	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant : 9□ Unknown	at time of de	eath 5□	Other (specify)				Wighth	Day 18ai
d	F	Part II. Other significant condition	s contributing to death	but not resu	ulting in the cu	nderlying cause giver	in Part I	23a Did	tobaccou	see contribute	to the cause of death?
	۵	END STAGE	RENAL						Yes 2		Probably 4 Denkno
	ete		_		<u> </u>					1	
1.2	du.	DIABETES M	ELLITU	7				24a. Was		24b. Were prior t death	autopsy findings availa o completion of cause : ?
4	-							1 ☐ Yes	2 □ No		es 2 No
						Other	26. Place of Dea			995	
ć	Be	25. Was case referred to medical examiner?	Hospital:		5010		4 ☐ Nursing H	lome 5 Res			pecify)
C C	To Be		Hospital: Inpat	ury	ER/Outpatien		at	280. Describe		,	
0	To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of In (Month, D	ury		28c. Injury		28d. Describe	now inqui		
C T	To Be	examiner? 1 Yes 2 No 27. Manner of Death Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no	28a. Date of In (Month, D	ury ay Year)	28b. Time of Injury	28c. Injury : Work? M 1 \(\sum Ye	at es 2 □No	28f. Location	Street an	d Number or	Rural Route Number,
1	To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of In (Month, D	ury ay Year)	28b. Time of Injury	28c. Injury			Street an	d Number or .)	Rural Route Number,
O or Total	Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no 4 Homicide 29a. Certifier (Check only 2 Medical Ex	28a. Date of In (Month, D) 28a. Place of Ir building, 6 28b. Place of Ir building, 6 Physician: To the besteminer: On the basis	njury - At ho stc. (Specify t of my know	28b. Time of Injury	28c. Injury work? M 1 Yeset, factory, office	es 2 No	28f. Location (City or To	Street an wn, State	and manner	as stated
C of the spinish of the spinish	ledical Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident 6 Could no 4 Homicide 6 Could no determine 29a. Certifier (Check only one) 2 Medical Ex	28a. Date of In (Month, D) tion t be ed 28e. Place of Ir building, s	njury - At ho stc. (Specify t of my know	28b. Time of Injury	28c. Injury Work? M 1 TY Deet, factory, office Doccurred at the time restigation, in my opin	es 2 No	28f. Location (City or To	Street an wn, State cause(s) date and	and manner I place, and d	as stated. ue to the cause(s)
To observe the contract of the	ledical Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no 4 Homicide 29a. Certifier (Check only 2 Medical Ex	28a. Date of In (Month, D) 28e. Place of In building, 6 Physician: To the besteminer: On the basis and manner s	njury - At ho otc. (Specify t of my know of examinat tated.	28b. Time of Injury	28c. Injury work? M 1 TY set, factory, office occurred at the time restigation, in my opin 29c. License	es 2 No	28f. Location (City or To , and due to the rred at the time,	Street an wn, State cause(s) date and 29d. Dat	and manner I place, and d	as stated. ue to the cause(s) nth, Day, Year)
C - H : Changing C	Medical Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident 6 Could no 4 Homicide 6 Could no determine 29a. Certifier (Check only one) 2 Medical Ex	28a. Date of In (Month, D) too t be 28e. Place of Ir building, 6 Physician: To the besteminer: On the basis and manner s	njury - At ho otc. (Specify t of my know of examinat tated.	28b. Time of Injury me, farm, stre viedge, death ion and/or inv	28c. Injury Work? M 1 TY Bet, factory, office coccurred at the time restigation, in my opin 29c. License	es 2 No	28f. Location (City or To , and due to the rred at the time,	Street an wn, State cause(s) date and 29d. Dat	and manner I place, and d	as stated. ue to the cause(s)

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) January **Physician** 2004 Рм Pfarr 6:57 Hiram /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Edgemere 9124 Avenue B | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | July 22 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 10 M 2□ F 217-05-5710 86 Yrs. Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Item 27 is marked other than "naturel", or Items 23a or 28e-f show other traumatic event, it a Medical Exemples must be notified at Baltimore 1 ☐ Yes 2 ☐ No Marvland Edgemere Directo 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 9124 Ave. 21219 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent Ever in U.S. Armed Forces? within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. þ Specify. white 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Auto Technician Automotive Electronics permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if Item 27 is marked oth any injury or other traumatic event 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Pfarr Tda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4935 Mountain Road Pasadena, MD 21122 Nancy Shoemaker daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Loundon Park Cemetery Jan 14 2004 Baltimore Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stallings Funeral Home P.A. 21. Signature of Fyneral Servi Lice 110 once <u>3111 Mountain Road Pasadena. Md 21122</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ardlo /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to for as a consequence of Examine -transit certificate be executed and Due to (or as a consequence of): **burial**-Box 68760, physician Physician/Medical the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a P.O. 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ Dertenson 225No 3 ☐ Probably 4 ☐ Unknown Completed peen Vas Cul 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed? 1 ☐ Yes 2ENO Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 Yes 2 X 3 DOA this 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 🗆 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 50 within 24 hours a To the Funerel C 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North Point BIVd # 700, Bultimore, 40 21226 2001 Stag 32. Registra Signature 31. Date filed (Month, Day, Year) State 2004 holdson. Registrar

			1 - For State Registrar	State	of Man	yland / D		tment o			id Me	-	giene Reg. No	/1111	+ 007	91
	Physici	an	1. Decedent's Name (First, Middle	-	1 (1 0	,				_	Date of De Month	Da	y, Year	3. Time of Dea	
•	/Medic	al	James Rob 4a. Fecility Name (If not institution			ord, S		4b. City. Tow	m arla	enting of F	1	Janua		4, 2004		1 M
	Examin	er	1223 W. Cross		umber)			Balti			Jeann .			/A	tn	
	Funeral		5. Social Security Number	6. Sex	7. Age (I	n yrs. last birth	day)	If Under 1 Y	ear If	f Under 24	Hrs. 8.	Date of Bir (Month, Da	th		thplace (State or Fo	reign
	Director		216-44-7221	1 DM 2□ F		56 ^Y	rs.	WOITIS D	iys	riours		ULY 1		947 Mar	yland	
	and and		Usual Residence of Decedent 10a. State 10b. County		10	0c. City, Town	or Loca	ation							10d. Inside City Li	imits
	Maryl -f sho	tor	Maryland N/A		F	Baltimo	re								1 XYes 2	□No
	h the	Director	10e. Street and Number			Darcino	ıc	10f. Zip Co	de				10g. Cit	izen of What C	ountry?	
	23a c	alD	1223 W. Cross	Street				21230)				USA			
	er dea	Funeral	11. Marital Status	12. Was De Armed F	Forces?	er in U.S.	13. W	as Decedent Yes, specify	of Hispa Cuban, I	anic Origin Mexican, P	? (Specif Puerto Ric	y Yes or No an, etc.)	-	14. Race - Am- Black, Whi		
50	F, or	by F	1 Never Married 2 TMarr 3 Widowed 4 Divorced	lf Yes, G Year or			1 [☐ Yes 2☐	No S	Specify:				Specify:	White	
2-00s	be tited within 72 hours after death with the Maryland that Hygiene. Id other than "natural", or tems 23a or 28a-f show event, I'ra Medical Examinat must be notified at		15. Deceden (Specify only higher	i's Education	41	16a. [Decede	nt's Usual O	cupatio	on in a most o	fundina		16b. K	ind of Business	/Industry	
7	ithin 7	Completed	Elementary/Secondary (0-12)		(1-4or 5+)		life. Do	O NOT use re	itired)							
7	fited w Hygier other th		7 17. Father's Name (First, Middle,	(act)		Ele	ctr	onics				irst, Middle			s Repair	
and	2 should be fited within and Mental Hygiene. Is marked other than surnatic event, the Me	o Be	Theodore Ru		a							Ho1n		Sumame)		
3	should be nd Mental marked c	2	19a. Informant's Name/Relations		u	19b. I	Mailing	Address (St						or Town, State,	Zip Code) 2123	
Z,	alth a		Margaret A.	Ruther	ford,	/Wife	12	223 W	. C	ross	Sti	reet		altimo		
ore	of He		20a, Method of Disposition 1 Burial 2 Commation	3 □Removal from	1	20b. Place of I cemetery	Disposi , <i>crema</i>	tion (Name of atory or other	f place)		Date		20c. Lo	ocation - City or	Town, State	
Saltimol	Pag tment tant: jury c		4 □Donation 5 □ Other (S	pecify)	/	Metro					-14-			ltimore	, MD	
מ	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic es <u>pncs</u> .		21. Signature of Fueral Service Edward A.	Greeorch	nik		²² C	Name and Adrenati 99 Fre	on deri	Societick R	ty o	f MD, Bali	Inc	re, MD	21228	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the	e death. Do no	ot enter	the mode of	dying, s	such as ca	rdiac or re	spiratory a	rrest,	· •	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a. LUA	U6 0	DNIER									Onset and Deat	
	/Medical Examiner		resulting in death)	Due to	o (or as a c	onsequ <i>e</i> nce of	·):									
L		er	Sequentially list conditions,	b. Due to	o (or as a c	onsequence of	n:									
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	С.												
Ď,	cate be executed physician and the burial-transit	EX	resulting in death) Last	Due to	o (or as a c	onsequence of	i):									
00/00	physic physic the b	dlcal		d												
XOC	nding use at	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o										23d. Date of de	livery	
Ď	death	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No		gnant at tim	Fetal death ne of death		ctopic pregn Other (specif)						Month	Day Year	
r 5	at the	Phys	9 Unknown													
cords,	The law requires that the death certif ite has been signed by the attending rage 2 should be detached for use a	by	Part II. Other significant condition	ins contributing to	death but h	not resulting in t	the und	lerlying causi	given i	n Part I.	_				the cause of death obably 4 DUnkn	
2	as be	Completed										24a. Was		24b. Were a	utopsy findings avai	lable e of
ב =	: The cate h	Соп										perfo	rmed? 2DNo	death?	2 🗆 No	
VILA	Physician: this certific rat director,	Be	25. Was case referred to medical examiner?	Hospital:	-				Other		5171.05	heck only o				
5	ding Physician: The lav h. After this certificate has funeral director, page 2	To :	1 ☐ Yes 2 ☒ No 27. Manner of Death	28a. Date	Inpatient e of Injury	2 ER/Outp	-	3□ DOA 28c.	njury at		-	5 X Reside I		6 □Other (Spe y occurred	cify)	_
2	Attanding ir death. actor: After by the funer	atlor	1 XNatural 5 ☐ Pendin 2 ☐ Accident investi	9	onth, Day Y	ea <i>r)</i> Inj	ury		Work?	3 2 □ No						
DIVISION	or Atta ter de iracto n by th	ertification;	3 Suicide 6 Could 4 Homicide determ	ined 289. Plac	ce of Injury ding, etc. (- At home, farn	n, stree	et, factory, off	ice		281	Location (; City or Tox	Street an vn, State	d Number or Ri	ural Route Number,	
ב 7 -	pital (O	29a. Certifier 1 Certifyin	g Physician: To th	he hast of -	ny knowlede:	dant	20011777		date and	lace ==	I dua to th		and core	a state of	
	To the Hospital or Attandi within 24 hours after death. To the Funaral Diractor: A completely filled in by the fu	edical	(Check only 2 Medical one)	Examiner: On the	basis of ex inner stated	amination and/	or inve	stigation, in r	ny opini	on, death	occurred	at the time,	date and	and manner as I place, and due	to the cause(s)	
	To t To t	Σ	29b. Signature and title of certifie	TALL PROPERTY OF					ense nu					te signed (Mont		
1	Á	1 %	Men			_		1	15	172			Jar	nuary 1	4, 2004	
4	1	1	30. Name and address of person	who completed car	use of deat	h (Item 23a) (T	ype, P	rint)	Du	00 -	2 7.	201				
478	Sta	te	ALG X KENDL 10. 31. Date filed (Month, Day, Year)		Registrans	Signature	4).	Full 17 6	, ,	الما لايما	0 (1	201				
	Registr		JAN	1 5 2004	> Be	elves 1	K	book	(and	4						

04-00299 RKD

RKD			1 - For Amend & Unpend	Item #1,254,27,28			lealth and M 3/04 tas Death	lental Hyg	iene	04 00792
	Physici	an	Decedent's Name (First, Middle, La	ast) Dennis James Rad	lford			2. Date of Deat Month	h	3. Time of Death
	/Medi		4a. Facility Name (If not institution, given	Dennis Jame	s kaa		or Location of Death	JANUARY	11, 20 4c. County of	004 7:19P. M
2	Examir	ier	JOHNS HOPKINS BAY		כושיוויותי	BALTIMO			4c. County C) Death
0	Funeral		5. Social Security Number 6. 5	Sex 7. Age (In yrs. I		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign Country)
300	Director		217-02-1768 Usual Residence of Decedent	12XM 2□F 37	Yrs.	Months Days	Hours Min.	(Month, Day, Dec 2,	1966	Country) Maryland
	show		10a. State 10b. County	10c. City	, Town or Lo	ocation				10d. Inside City Limits
	the Ma 28a-f s	cto	MD Montgor	nery San	dy Spi	cing				1 ⊈Yes 2 ☐ No
	ath with the Maryla 23a or 28a-f shov	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of W	hat Country?
	e 23e	rai	1610 Olney Sandy	· · · · · · · · · · · · · · · · · · ·		20860			U.S.A.	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or tieme 23a or 28a-f show into the Musical Exercine regar be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1	Was Decedent of H If Yes, specify Cub: 1□ Yes 2፟፟፟ No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	Black	- American Indian, , White, etc. White
9	72 hou natura		15. Decedent's E		16a. Deced	dent's Usual Occup	pation	1	6b. Kind of Bus	
215	hin 7.	Completed	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of worki	ng		,
	filed within Hygiene. other than	СОП	12		Tree	Speciali	st		Agricul	ture
nd	m - 0 5	Be (17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, M	laiden Sumame)
yla	should be nd Mental marked o	ို	Dennis James Radi				Maggie R			
Maryland			19a. Informant's Name/Relationship (and Number or Rura			
	s 1 and 2 if Health item 27 i		Maggie R. Eldrido 20a. Method of Disposition					-		ing, MD 20860
آور	0 0		1 Burial 2 Cremation 3	Theilioval Ilolli State		sition (Name of natory or other place	ı	/a(e) 2	Oc. Location - C	City or Town, State
tin			'4 □ Donation 5 □ Other (Special Septical Septi	1 - 12		Cemetery				Maryland
Ba	permit. Departr Imports any inje		Now iff yal	M007	73 3	13 Talbo		aurel, M	aryland	20707-4389
760,	Physician /Medical Examiner popularial-transit	cai Examiner	23a. Part1. Enter me disease, or com shock, or hear failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, fan, land the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	ication ence of):					Approximate Interval Between Onset and Death
	I the death certifica by the attending ph ached for use as th	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregnan 1	death 3 ath 5	Ectopic pregnancy Other (specify)			23d. Date Monti	of delivery h Day Year
rds, F	w equires that b⊷en signed l should be det	d by P	Part II. Other significant conditions of	ontributing to death but not resul	lting in the ur	nderlying cause give	en in Part I.			oute to the cause of death? B Probably 4 Unknown
Division of Vital Records,	vician: The law er certificate has bee rector, page 2 sho	e Completed	25. Was case referred to medical					24a. Was an autopsy perform	ed? de □ No 1/0	ere autopsy findings available or to completion of cause of ath?
>	ding Phyeician: n. After this certific funeral director.	To Be	examiner? 1 √Yes 2 No	Hospital: 1 ☐ Inpatient 21 ☑ E	R/Outpatient	t 3 DOA Othe	26. Place of Death	ne 5 Residen		(00.04)
0	g Phye er this eral di	n:	27. Manner of Death		28b. Time of	28c. Injun Worl		8d. Describe how		
jo	Attending F r death. sctor: After by the funer	atio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury unknown		Yes 2X No	Iblmora		
Divis	al or Atte s after dei il Directo id in by th	3 Suicide 3 Suicide 4 Homicide 4 Homicide 4 See Place of Injury At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury At home, farm, street, factory, office building, etc. (Specify)								North Point Rd.
	Hosp 4 hou Fune (ely fil	Medical (29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	nysician: To the best of my know miner: On the basis of examination and manner stated.	ledge, death	occurred at the timestigation, in my of	ne, date and place, a	Oundalk, M and due to the cau and at the time, dat	se(s) and mann	ner as stated. d due to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier			29c. License	number	290	d. Date signed ((Month, Day, Year)
			1 Horse	WW)		0.	C.M.E.	J	ANUARY	12,2004
			30. Name and address of person who	completed cause of death (Item		Print)				and 21201
	Sta Registr		31. Date filed (Month, Day, Year)	2004 32. Registrar's Signatu	ıre	Som		C. CHIOLC	, mary 1	MAR ELEVI

			1 - For State Registrar	State of M	/larylan		artmen tificate			and M	lental Hy	giene Reg. No.	200	4	00793
	Physici /Medic			lding							January	10,02		ear	3. Time of Death 11:00 a _M
	Examir	er	4a. Facility Name (If not institution, given 1315 Chesaco Avenue	- Apt.123			Rose	dale	Location			Ba	1timor	е	
1. Al	Funeral Director		5. Social Security Number 216–18–7529 Usuel Residence of Decedent	i□ M 2 √□ F	85	last birthday) Yrs.	If Under Months	Days	If Under Hours	Min,	8. Date of Bir Month, D. August	9,191	8 P	Birthpl Count COUNT COUNT	ece (State or Foreign Vivannia
	e Maryland 8a-f ehow diffed at	ctor	10a. State 10b. County MD Baltin	nore		y, Town or Lo sedale									0d. Inside City Limits
	23a or 21	Funeral Director	1315 Chesaco Avenue-	Apt. 123			10f. Zip 21	23 7				10g. Citi: U.S	zen of Wha .A.	at Count	ry?
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: If Item 27 is marked other than *natural; or Items 23e or 28e-f ehow appring yor other traumatic avent, I'me Medical Examinan must be rutified at ance.	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1 Yes 2 If Yes, Give A Year or Dates	s?		Vas Deced Yes, spec		spanic Ori n, Mexican Specify:	gin? (Sp n, Puerto	ecify Yes or No Rican, etc.)		14. Race - Black, \ Specify: W	White, e	
21215-0036	within 72 ho lene. rthan *natur ine Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		r 5+)		lent's Usua kind of wor DO NOT us minist	k done d e retired)	uring mos				nd of Busin		Administratio
Maryland 2	should be filed nd Mental Hyg i markad other umatic avent,	To Be C	17. Father's Name (First, Middle, Last John McNamara Redd	ng					18. Mothe	ors Namo	e (First, Middle Ahern	, Maiden	Sumame)		
e, Mar	1 and 2 sha Health and em 27 is m), E	James Redding II - 1 20a. Method of Disposition		20b. P	1828 H	arford	Road	Balt	timore	al Route Numb Maryl a Date	nd 21			
altimore,	permit. Pages Department of I Important: If Ite any injury or o		1 Burial 2 Cremation 3 4 Donation 5 Other (Special Signature of Funeral Service Lice	(y)	" Ne	w Cathed 22	-	meter	y 1/	/13/04 y Le	1 eonard J.	Balti	more, l		
aă E	4 0 E 4 8		23a. Part 1. Enter the disease, or con	plications that caus	ed the death					Baltir	more, Mar	yland	-		Approximate Interval Between
8760,	death certificate be executed e attending physician and for use as the burial-transit for use as the burial-transit	dical Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Aca Due to (or a	as a consequence of a seconsequence of the seconsec		ys c	V	asu	(ila	Int	are bi e	ATom use		Onset and Death O With
P.O. Box 68	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 ☐ Feta at time of d	Ideath 3	Ectopic pre					2	3d. Date of Month		y Day Year
	res bed	þ	Part II. Other significant conditions	contributing to death	but not resi	ulting in the un	nderlying ca	luse give	n in Part I.			obacco us		te to the	cause of death?
al Reco	The ate h page	Completed									24a. Was autop perfo		24b. Werd prior deat 1 🗌	h?	sy findings available pletion of cause of
Division of Vital Records,	I or Attending Physician: The after death. Director: After this certificate in by the funeral director, pag	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 25 No 27. Manner of Death 15 Natural 5 Pending investigation 2 Accident 3 Suicide 4 Homicide 6 Could not 8 determined	e 28e. Place of I	njury Day Year)	ER/Outpatient 28b. Time of Injury ome, farm, stre	M 28	A Othe Bc. Injury Work 1 \(\text{Y}	r: 4 □ Nu	rsing Ho	me Resident 28d. Location (City or Tou	dence 6 how injury	occurred		
	Hospital 4 hours Funeral ely filled	edical Ce	29a. Certifier (Check only one) (Check only one) (Check only one)	nysician: To the besininer: On the basis and manner	of examina	wledge, death tion and/or inv	occurred a estigation,	at the time in my op	e, date an inion, dea	d place, th occurr	and due to the ed at the time,	cause(s) a	and manne place, and	er as sta	ted. he cause(s)
		Me	29b. Signature and title of certifier	omavi,	MI	> .		License	52	016	>		signed (M	21	04
	2.		30. Name and address of person who	ava, Zo	-	II re	Print)	Tre	ect,	# 6	so, E	act	t/mo	N.	M DNM2
	Sta Registi		31. Date filed (Month, Day, Year) JAN 1 5 20	04 32. Regis	-	iture									

			For State	State of Marylar		artment of h		nd Ment		00	\cap I	00701
			1 - State Registrar		Ce	runcate or	Dealli	10.0	Reg. ate of Death	No U	Uho	3. Time of Death
	Dharaisi		Decedent's Name (First, Middle, Last)							Day Y	rear .	
	Physici /Medic	al	JOSEPH, HE		MOSE	R					34	9.05 PM
>	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of	Death	11	4c. County of		
			GOOD SAMARI	TAN HOSPI	TAL		TIMO			BALT		
	Funeral		5. Social Security Number 6. Sec		. (ast birthday)	If Under 1 Year Months Days		4 Hrs. 8. Da Min. (N	ate of Birth fonth, Day, Ye	ar)	Birthpla Countr	ace (State or Foreign ry)
	Director		213-30-5683	70	Yrs.			May	6,193	3 M	aryl	and
	p ,	}	Usual Residence of Decedent 10a, State 10b, County	10c C	ity, Town or Lo	ncation					10	d. Inside City Limits
	aryla shov	_	,		.,,							1 ☐ Yes 2 ☑ No
	Ba-1	cto		ltimore			Rosedal	Le	40-	Citizen of Wh		2
	15 th	Director	10e. Street and Number			10f. Zip Code	0100					•
	23a	la l	6700 Bowleys Lar			1	21.23			United 14. Race		
	r de	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of I If Yes, specify Cub	an, Mexican,	Puerto Rican	, etc.)		White, e	
ဓ္က	or if	by Fi	1 Never Married 2 Married	1 ⊠Yes 2 □ No If Yes, Give		1 ☐ Yes 2 🔀 No	Specify:			Specify:	1	White
ë	ural	q p	3 ☐ Widowed 4 🖒 Divorced		rean	dent's Usual Occu	nation		166	. Kind of Busi		
rγ	"nat	lete	15. Decedent's Edu (Specify only highest grad	le completed)	(Give	kind of work done DO NOT use retire	during most o	of working	100	. 14110 01 000		,
12	withir	Completed	Elementary/Secondary (0-12) 12 Years	College (1-4or 5+)		emetery M				Buria	1 / 0	Cemetery
2	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ont, the Mydical Evar it art innel to notified at	ပိ	17. Father's Name (First, Middle, Last)						t, Middle, Maid			
ä	ntal ed o) Be	Joseph H. Romose	er. Sr.			Ca	therin	e Conr	оу		
<u>-</u>	should be f and Mental I s marked of sumatic eve	ို	19a. Informant's Name/Relationship (T)	•	19b. Maili	ing Address (Street	t and Number	or Rural Rou	te Number, Ci	ty or Town, St	tate, Zip (Code)
ĕ	d 2 s th an t7 Is		Kenneth Romoser		6700	Bowleys	Lane	Rosed	lale, M	arylan	d 2:	1237
a,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mendal Hygiene. Important: If item 27 Is marked other than "natural; or items 23a or 28a-1 show amy injury or other traumatic event, the Medical Erarch et mast be notified at ancie.		20a. Method of Disposition	20b.	Place of Dispe	osition (Name of		Date	20c	. Location - C	ity or Tow	vn, State
Baltimore, Maryland 21215-0036	ages nt of nt of r: If it		1 Burial 2 ☐ Cremation 3 ☐ F Donation 5 ☐ Other (Specify)	Hemoval from State	-	matory or other pla	}			Dunda	alk,	Maryland
量	it. P intime injury		21. Signature of Funeral Service Lens		1 2	nislaus (2. Name and Addr	ess of Facility	1500	70.			
Ba	Departing Department of the particular of the pa			Chush		uda-Ruck 922 Wise	Funer	al Hom	e of Du	ındalk, land	2122	2•
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the dea	ath. Do not en	922 Wise ter the mode of dy	ing, such as c	ardiac or resp	piratory arrest,	10110		Approximate
			shock, or heart failure. List only o									Interval Between Onset and Death
}	Physician /Medical		disease or condition resulting in death)	a. ANCXII		AIN IN	JURY				_	24 hrs.
	Examiner			· ·		0 000	VITUO					34 has
		J.	Sequentially list conditions,	b. VENTR Due to (or as a conse	quence of):	K TIKK	7 IMIO	CIT	,			15 yrs.
	ted nsit	Ë	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									15475
	al-tra	Examiner	that initiated events resulting in death) Last	c. ISCHEN Due to (or as a conse	quence of):	<u> </u>	17100	1_3_				
68760,	icate be executed physician and s the burial-transit	calE		d					_			
587		_	His-	<u>. </u>						1		
×	certi nding se as	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr						23d. Date	of deliver	у
Вох	that the death certif ed by the attending detached for use a:	Physician/Med	in the past 12 months?	1□Live birth 2□Fet 4□Pregnant at time of		□Ectopic pregnand □ Other (specify) _	у			Mont	h [Day Year
P.O.	the d y the ichec	ıys	9 ☐ Unknown	9□ Unknown								
	res that signed b	F P	Part II. Other significant conditions co	ontributing to death but not re	sulting in the t	underlying cause gi	iven in Part I.	2	23e. Did tobac	co use contrib	oute to the	e cause of death?
ds	uires sigr ld be	Q D	END STAGE	RENAL DI	SEASE	·		_	1 🗌 Yes	2 □ No 3	Proba	ibly 4 Unknown
Vital Records,	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	Completed by	A 50.01 5.00	11 17:001				2	24a. Was an	24b. We	ere autop	sy findings available
Re	has ge 2	Ę.	ATRIAL FIBRI	CCHIDIV					autopsy	1?/ de	ath?	pletion of cause of
a			os ut				OR Bloom	of Death (Che	Yes 2	No 1 L	Yes 2	2 No
Ξ	Physiclan: The I this certificate har ral director, page	Be	25. Was case referred to medical examiner?	Hospital: 1 Umpatient 2 D		-1 20 DOA 01	han		5 ☐ Residence	a 6 ∏Other	(Specify)	1
o	Phys r this ral dii	- To	1 Yes 2 No	28a. Date of Injury	28b. Time of	-		-	Describe how i			
L C	ding After fune	ion E	1 Natural 5 Pending	(Month, Day Year)	Injury		ork?]Yes 2.∐N	10				
i <u>s</u>	death death stor: / the	cai	3 Suicide 6 Could not be		home, farm, st	reet, factory, office					or Rural	Route Number,
Division of	or A after Direct in by	Certification;	4 Homicide determined	building, etc. (Spec	cify)	,,		0	City or Town, S	tate)		
<u>-</u>	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the tuneral di		29a. Certifier 1 Certifying Phy	ysician: To the best of my kr	nowledge, dea	th occurred at the t	time, date and	i place, and d	ue to the caus	e(s) and man	ner as sta	ited.
	he Ho in 24 t he Fu pletely	edical	one)	niner: On the basis of examinand manner stated.	nation and/or it			n occurred at				
	To the within 2. To the complet	Σ	29b. Signature and title of certifier	l- _{ss}	34 5		ise number		290.	Date signed		-
		0.	> Inother		MS	KE:	5 000	J		1/9	101	4
1	+1		30. Name and address of person who o	completed cause of death (Ite	em 23a) (Type	, Print)		01-		AA	a	26
_	,		ZEEBA MATHEWS	, 5601, LO	CH RAI	VEN BLU	D, B	HLIIM	OKE	- W/D	212	- 3 7 .
	St: Regist	ate rar	31. Date filed (Month, Day, Year)	., 56 c \ Lo32. Registrar's figr	Super 1	& sport	25					

State Registrar 31. Date filed (Month, Day, Year)

JAN 1 5 2004

DHMH 17 Rev 1/2001

JANUARY

14

32. Registrar's Signature

Dulaney Vall

MONIUM

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 235 Month Year **Physician** AN MARGARET CATHERINE RAAB 2004 /Medical 4b. City, Town, or Location of Death 4e Fecility Name (If not institution, give street end number) 4c. County of Death Examiner ELAIR MARINER HEALTH OF BELAIR If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 □ M 280 F Yrs. 218-12-2010 28, 1922 Director 81 Feb. Maryland Usuel Residence of Decedent nit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland and remost of Hauth and Mentel Hygiene.

ortant: if item 27 is marked other than "natural", or items 23s or 28s-f show hortant: if item 27 is marked other than "natural", or items 23s or 28s-f show hortant in items and the inciting at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County MXYes 2 □ No Director Maryland Harford Aberdeen 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21001 Completed by Funeral 700 West Bel Air Avenue USA 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes ŽQNo
If Yes, Give
Year or Dates: 1 □ Never Merried 2 □ Married Baltimore, Maryland 21215-0020 Specify: 1 ☐ Yes 2000No Specify: White 3€CWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Hoehn Elizabeth Catherine Ruppel Andrew Jacob 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary D. Rose - Daughter 1910 Park Beach Drive, Aberdeen, MD 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1

Buriel 2 □ Cremation 3 □ Removal from State Sacred Heart of Jesus 1/14/04 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Juneral Service Licenses 1317 Cokesbury Rd., Abingdon, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 3 Wee Examiner Physician/Medical Examiner attanding physician and for use as the bunal-transit Attanding Physician: The law requires that tha daath certificeta be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Due to (or as e consequence of): certificate hes been signed by tha attanding irector, page 2 should be detached for use as Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown À 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed 1 Yes 200 1 ☐ Yes 2 ☑ No Director: After this certific d in by the funeral director, 25. Was case referred to medical Be Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Ne 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Dev Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No daath. investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide To the Hospital of within 24 hours a To the Funeral D 29a. Certifier contifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. edicai (Check only Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 29d. Date signed (Month, Day, Yeer) 29b. Signature and title of certifier (Item 23e) (Type, Print 30. Name end address of person who completed cause

DHMH 16 Rev 6/95

State Registrar

Nargaret

32. Regist

Mauxana

		1 - For State Registrar	State of Ma		partment of e <i>rtificate o</i>			giene2 ()	04 00797
		1. Decedent's Name (First, Middle, La	ast)				2. Date of De	ath	3. Time of Death
Physicia /Medic		Richard Cle	mens Sch	e11			Januar	v 13. 2	004 1:15 A ^M
Examin		4a. Facility Name (If not institution, gire	ve street and number)		4b. City, Town	, or Location of Death		4c. County	
		Joseph Richey Ho	ospice		Baltim	ore		N/A	
neral		,		(In yrs. last birthda)		ar if Under 24 Hrs.	8. Date of Birt (Month, Da		Birthplace (State or Foreign Country)
tor		203-30-0700	1 X M 2 □ F	63 Yrs.			DEC 15		Florida
		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or I	_ocation				10d. Inside City Limits
	5	Maryland Baltimo		Dundalk					1 □Yes 2 ⊋No
200	ect	10e. Street and Number	JIC .	Dundark	10f. Zip Code	<u> </u>		10g. Citizen of	Λ_
Ì	0	7105 Dunshire Wa	av #Δ1		21222			USA	That Gouldy?
	by Funeral Director	11. Marital Status	12. Was Decedent Ev	rer in U.S. 13		f Hispanic Origin? (Spuban, Mexican, Puerto	ecify Yes or No		e - American Indian,
	Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 No				Rican, etc.)	Bla	ck, White, etc.
	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give X Year or Dates:		1□Yes 2₩N	o Specify:		Specify	White
	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dec	edent's Usual Occ	upation ne during most of work	ina	16b. Kind of B	usiness/Industry
	du	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use reti	red)		0. 1	. 1 .
		12		Tron	Worker				Industry
	Be	17. Father's Name (First, Middle, Last				18. Mother's Name		Maiden Suman	re)
	2	Lawrence Benjami	The second second			Myrtle			
1		19a. Informant's Name/Relationship (Sandra Krell/Fiar			_	et and Number or Rura e Way #A1			
	8	20a. Method of Disposition	icee	20b. Place of Disp			Dunga	1k, MD	21222 Situate Favor State
		1 ☐ Burial 2 X Cremation 3 [cemetery, cre	ematory or other p	lace)			City or Town, State
		*4 □ Donation 5 □ Other (Speci			rematory		4-04	Baltim	ore, MD
		21. Signature of Puneral Service Lice	n/		22. Name and Add Cremation	n Society (of MD.	Inc.	
			regorchik			erick Road	Balt	imore, 1	AD 21228 Approximate
		23a. Part1. Enter the disease, or on shock, or heart failure. List only Immediate Cause (Final						1651,	Interval Between Qnset and Death
an al		disease or condition resulting in death)	a Met	astatio	uno	cance	r		1 year
er			Due to (or as a	consequence of):	0	ė.			O
4	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequence of):					
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
	Exa	resulting in death) Last	Due to (or as a	consequence of):					
	cai	(d						
	led								
	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 Live birth 2		□Ectopic pregnan	ev.		23d. Dat	e of delivery
	Sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at tir 9☐Unknown		Other (specify)			Moi	nth Day Year
	Phy	9 Unknown			·				
	by	Part II. Other significant conditions	contributing to death but	not resulting in the	underlying cause g	given in Part I.	İ		ibute to the cause of death?
-1	ted						1 🗆 Y	es 2 No	3 Probably 4 Unknown
							24a. Was a		Vere autopsy findings available rior to completion of cause of
	n pi						perfor	med2 c	eath? □Yes 2⊡ No
	Comple					26. Place of Death	Check only or	10 8:	hea
	Be Completed	25. Was case referred to medical examiner?						2001	
	To Be	examiner? 1 ☐ Yes 🌠 No		2 ER/Outpatre	IN 3 DOA	ther: 4 🗆 Nursing Hor	ne 5 🗆 Resid	ence 6 Dotne	or (Specify) has as a
l	To Be	examiner? 1 Yes No 27. Manner of Death	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day)	28b. Time of	of 28c. Inj	ther: 4 Nursing Horury at ork?		ow injury occurr	1109110
l	To Be	examiner? 1 Yes No 27. Manner of Death 1 Matural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day)	(ear) 28b. Time (Injury	of 28c. Inju	ther: 4 Nursing Hor ury at 2 ork? Yes 2 No	28d. Describe h	ow injury occurr	ed 1109/21 G
	To Be	examiner? 1 Yes No 27. Manner of Death 1 Matural 5 Pending	28a. Date of Injury (Month, Day)	(ear) 28b. Time (Injury)	of 28c. Inju	ther: 4 Nursing Hor ury at 2 ork? Yes 2 No	28d. Describe h	ow injury occurr	1109110
	Certification: To Be	examiner? 1 Yes No 27. Manner of Death 1 Accident	28a. Date of Injury (Month, Day y 28e. Place of Injury building, etc.	28b. Time (Injury) - At home, farm, st	of 28c. Inj. M 1[treet, factory, office	wher: 4 \(\text{ Nursing Hor ury at ork?} \) Yes 2 \(\text{ No } \)	28d. Describe h 28f. Location (S City or Town	ow injury occurr treet and Number n, State)	er or Rural Route Number,
l	Certification: To Be	examiner? 1	28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc. 1 1 1 28e. Place of Injury building, etc. 1 1 1 1 1 1 1 1 1 1 1 1 1	Year) 28b. Time of Injury At home, farm, st (Specify) my knowledge, dea kamination and/or in	of 28c. Injury M 1[treet, factory, office	time date and place a	28d. Describe h 28f. Location (S City or Tow	ow injury occurretreet and Number, State)	er or Rural Route Number,
l	To Be	examiner? 1 Yes No 27. Manner of Death 1 Accident 2 Accident 3 Suicide 4 Homicide 29a. Certifier 1 Certifying Ph	28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc.	Year) 28b. Time of Injury At home, farm, st (Specify) my knowledge, dea kamination and/or in	of 28c. Inj W 1[treet, factory, office th occurred at the nvestigation, in my	time date and place a	28d. Describe h 28f. Location (S City or Tow and due to the c ed at the time, d	ow injury occurrence and Number of the tand Number of the tand Number of the tand of tand of tand of the tand of tand	er or Rural Route Number, nner as stated. nd due to the cause(s)
l	Certification: To Be	examiner? 27. Manner of Death 1	28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc. 1 1 1 28e. Place of Injury building, etc. 1 1 1 1 1 1 1 1 1 1 1 1 1	Year) 28b. Time of Injury At home, farm, st (Specify) my knowledge, dea kamination and/or in	of 28c. Inj W 1[treet, factory, office th occurred at the nvestigation, in my 29c. Licer	time, date and place, a opinion, death occurrences number	28f. Location (S City or Tow and due to the c ed at the time, d	treet and Number, State) ause(s) and mailate and place, a	er or Rural Route Number, nner as stated. nd due to the cause(s) (Month, Day, Year)
	Certification: To Be	examiner? 1	28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc. 1. To the best of injury and manner state	'ear) 28b. Time Injury At home, farm, si (Specify) my knowledge, dea kamination and/or ind.	of 28c. Inj W 1[treet, factory, office th occurred at the nvestigation, in my 29c. Licer	time, date and place, a opinion, death occurrences number	28f. Location (S City or Tow and due to the c ed at the time, d	treet and Number, State) ause(s) and mailate and place, a	er or Rural Route Number, nner as stated. nd due to the cause(s) (Month, Day, Year)
	Certification: To Be	examiner? 1 Yes No 27. Manner of Death 1 Matural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined 29a. Certifier 1 Check only one) 29b. Signature and title of certifier 30. Name and address of person who	28a. Date of Injury (Month, Day y 28e. Place of Injury building, etc. nysician: To the best of a miner: On the basis of ey and manner state	rear) 28b. Time Injury At home, farm, st (Specify) my knowledge, dea camination and/or in the (Item 23a) (Type	of 28c. Inj W 1[treet, factory, office th occurred at the nvestigation, in my 29c. Licer	time, date and place, a opinion, death occurrences number	28f. Location (S City or Tow and due to the c ed at the time, d	treet and Number, State) ause(s) and mailate and place, a	er or Rural Route Number, nner as stated. nd due to the cause(s) (Month, Day, Year)
	Medical Certification: To Be	examiner? 1	28a. Date of Injury (Month, Day y 28e. Place of Injury building, etc. nysician: To the best of a miner: On the basis of ey and manner state	28b. Time (Injury) At home, farm, st (Specify) my knowledge, dea (amination and/or ind). th (Item 23a) (Type	of 28c. Inj W 1[treet, factory, office th occurred at the nvestigation, in my 29c. Licer	time, date and place, a opinion, death occurrences number	28f. Location (S City or Tow and due to the c ed at the time, d	treet and Number, State) ause(s) and mailate and place, a	er or Rural Route Number, nner as stated. nd due to the cause(s)

			1 - For State Registrer		larylan		artment rtificate			nd Mental H	Reg. No	200	4 00798
	Physici /Medio Examin	al	Decedent's Name (First, Middle Donald McKee St. Aa. Facility Name (If not institution.)	oner)	•	4b. City, 1	Town, or l	Location of	2. Date of Death	Da 2VV	8 ZE	504 9:07 PM
	Funeral		Union Memorial 5. Social Security Number	6. Sex 7. A		last birthday)	If Under	timoi 1 Year Days	If Under 2	4 Hrs. 8. Date of B Min. (Month, D		N/A	Birthplace (State or Foreign
	Director		219-34-1144 Usual Residence of Decedent	1XM 2□F	68	Yrs.		Days	Hours	March	18, 1	.935 M	laryland
	ne Maryla 8a-f shov ziilied al	ctor	Maryland N/A		1	y, Town or Lo ltimor	е						10d. Inside City Limits 1 X Yes 2 □ No
	th with the 23s or 2 ust be n	Funeral Director	10e. Street and Number 700 W. 40th St.				10f. Zip (_	tizen of What Lted St	
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Impartment of Heath and Mental Hygiene. Impartment of Heath and Mental Hygiene any injury or other traumatic event, Itte Medical Examiner must be notified at 90ce.	þ	11. Marital Status 1 XX Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces' ied 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	?		Was Decede If Yes, speci 1 ☐ Yes 2	***	panic Orig , Mexican, Specify:	in? (Specify Yes or N Puerto Rican, etc.)	10-	Black, Wi	merican Indian, hite, etc. white
Maryland 21215-0036	d within 72 h giene. er than "natu the Medical	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education it grade completed) College (1-4or 2	5+)	16a. Dece (Give life. medica	dent's Usual kind of work DO NOT use al rec	k done du e retired)	ring most			ind of Busines	
yland	ould be fite Mental Hyg arkad othe atic event,	To Be C	17. Father's Name (First, Middle, Elmer Aughesy S	•					Josep	's Name <i>(First, Middle</i> hine McKee	3		
re, Mar	Tand 2 sho Health and tem 27 is m other traum		19a. Informant's Name/Relationsl Chester Hobbs/g 20a. Method of Disposition		20b. P		Susqu	ıehan	ına Av	or Rural Route Number Tows	on, l	MD 212	
Baltimore,	nit. Pages partment of cortant: If it injury or of		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S) 21. Signature of Funeral Service	pecify)		enmoun	t Cre	mato	ry Ja	n. 10,2004	Bai	1timore	e, Maryland
ä	lmp any any		23a. Parl . Enter the disease, or mock, or heart failure. List	litchell	d the deeth	n. Do not ent	Mi 650 er the mode	tche. UU Yo of dying,	II-Wi ork R such as c	edefeld Fu d. Balti ardiac or respiratory	inera Imore arrest,	Home , MD	Approximate
	hysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	eur	noni							Interval Between Onset and Death
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as c. Due to (or as									
.O. Box 6	w requires that the death certific been signed by the attending p should be detached for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	Ectopic pre					23d. Date of d Month	elivery Day Year
ords, P	equires that en signed b ould be deta	Ď	Part II. Other significant condition	ns contributing to death b	out not resu	ilting in the ur	nderlying car	use given	in Part I.		tobacco u Yes 2[to the cause of death? Probably 4 nknown
al Records,	։ The law ո icate has be r, page 2 shi	Completed								24a. Was auto perfe 1 🗆 Yes		24b. Were a prior to death? 1 ☐ Ye	
Division of Vital	To the Hospital or Attending Physicien: The lan within 24 Hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	atlon: To Be	25. Was case referred to medical examiner? 1	ation		ER/Outpatien 28b. Time of Injury		Other: c. Injury a Work?	4 🗆 Nurs	ing Home 5 Resi 28d. Describe	idence (6 Nother (Sp y occurred	ecity) ER
É	urs after de rral Diracto lled in by t	Certification:	3 Suicide 6 Could n 4 Homicide determi	ned 286. Place of in building, et	c. (Specify)				City or To	wn, State,)	Rural Route Number,
/	To the Hospital or Attency within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) 2 Medical E	g Physician: To the best exeminer: On the basis of and manner st	f examinati	vledge, death ion and/or inv	restigation, i	t the time, n my opin License n	ion, death	place, and due to the occurred at the time,	date and	place, and du	as stated. le to the cause(s) oth, Day, Year)
	5 - 8 - 8		30. Name and address objerson	yho completed cause of o	leath (Item	23a) (Type	Print)	D6	058	Nemosia.	01	08/	2004
	Sta	te	31. Date filed (Montal), "pan	00 mg	ar's Signat	201	un	* .	Site	1 .	J	> ANG	*
A	Registr		Aut 1 1	2004	Out S.	19	346			-			

		1 - For State Registrar	State of Maryland	-	artment of rtificate of		F	Reg. No.	00799
Physic /Medi			ORROW				2. Date of Dea Month	Aiy 17 70	
Examil Funeral Director	ner	4a. Facility Name (If not institution, give Lorien Nursing H. 5. Social Security Number 189-20-8988 10	ome		4b. City, Town, Columb If Under 1 Year Months Days	ia If Under 24	Hrs. 8. Date of Birtl	4c. County of Dea Howard p, Year) 9. Bi C 8,1926 Per	rthplace (State or Foreign ountry)
n the Maryland r 28a-f show	Director	Usual Residence of Decedent 10a. State 10b. County Florida Charle 10e. Street and Number	· · · · · · · · · · · · · · · · · · ·	ort Ch	narlotte			10g. Citizen of What C	10d. Inside City Limits 1 ☑ Yes 2 ☐ No ountry?
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene, is marked other than "naturel", or Items 23a or 28a-f show eumatic event, the Medical Examinar must be recitified at	by Funeral	849 Dobell Terra 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2CE 12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:				? (Specify Yes or No- uerto Rican, etc.)		
Maryland 21215-0036 td 2 should be filed within 72 hours all th and Mental Hygiene. 27 Is marked other than "naturel", or treumetic event, the Medical Exam.	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12	ucation de completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retire	ipation during most of ed)	f working	16b. Kind of Busines:	
yland out be filed in Mental Hyge barked other latic event,	To Be C	17. Father's Name (First, Middle, Last) Raymond Moyer				Lula	Name (First, Middle, Sally Ryl.	and	
re, Mar 1 and 2 sh Health and tem 27 is m		19a. Informant's Name/Relationship (7 Myla Baker (Dau) 20a. Method of Disposition	ghter)	5827		Road S		or, City or Town, State, MD 21784 20c. Location - City o	
Baltimore, Maryla permit. Pages 1 and 2 should Department of Health and Men important: if tem 27 is marke any injury or other treumatic sines.		1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service License	Dru	id Rid	lge Cemet	ery 1		Pikesville,	
O EBEES		23a. Part1. Enter the disease, or comp shock or heartfailure. List only of Immediate Cause (Final disease or condition	olications that caused the death one cause on each line.	Ca n. Do not ent	tonsvil	le, Mary	yland 21228	8	Approximate Interval Between Onset and Death
ate be executed the behavior of the burial-transit appropriate	licai Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of the consequence o	uence of):					
.O. Box 68 the death certifica y the attending ph	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1□Live birth 2□Fetal 4□Pregnant at time of de	death 3	□Ectopic pregnan	су		23d. Date of de Month	Hivery Day Year
Records, P.O. In the law requires that the de thas been signed by the age 2 should be detached it	þ	Part II. Other significant conditions of DEMENTIA	ontributing to death but not resu	ulting in the u	nderlying cause g	iven in Part I.	1□Y	-	Probably 4 DUnknown
tal Rec an: The law tificate has t	Be Completed	25. Was case referred to medical				26. Place of		prior to death? 2 No 1 Ye	utopsy findings available completion of cause of s 2 No
Division of Vital Re To the Hospital or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificate hat completely filled in by the funeral director, page	2	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. Inj		28d. Describe h	dence 6 Other (Sp.	ecify)
DIVISION DITAIN OF Attendurs after death or attendeath or	Certification;	3 Suicide 6 Could not be determined	building, etc. (Specify	<i>(</i>)			City or Tow		
To the Hospital within 24 hours a To the Funerel I completely filled	Medical		ysician: To the best of my kno- iner: On the basis of examinal and manner stated.		vestigation, in my		occurred at the time, o		e to the cause(s)
())		30. Name address of person who	completed cause of death (Item	> 1 23a) (Type,	Print)	6056	0	JANOARY SALTIMORE	13 2004
St Regis	ate trar	PANKAT KHETER 31. Date filed (Month, Day, Year) JAN 1	PAV 201-199 32. Regist s Signa 5 2004 ▶ Segue	ture	South South	2 NEC	K RD. B	SALTIMORE	, MD

				State of Ma	ryland / D		ent of H	lealth and	Mental Hyg	iene 🗸 🤝	e. 14 00800
	Physici /Medic	cal	Decedent's Name (First, Middle, Last) Louis J. 4a. Facility Name (If not institution, give si		hmitt	4h Ci	ty Town o	Location of Dea	2. Date of Dea Month January	th Day Ye	
	Funeral Director	ier	71 Yew Road 5. Social Security Number 6. Sex 213 30 4109		(In yrs. last birtl		Ess		8. Date of Birth	Baltin (Year) 9.	
	he Maryland 8e-f ehow	Director	Usual Residence of Decedent 10a. State Maryland Baltimore	1	10c. City, Town Es	or Location SeX					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th with the 23a or 2	ai Dire	10e. Street and Number 71 Yew Rd.			10f.	Zip Code 212	21	1	0g. Citizen of Wha USA	t Country?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 le marked other then "natural", or Items 23e or 28e-f ehow apply injury or other treumatic event, the Medical Example must be notified at ance.	by Funerai	11. Marital Status 1 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent E Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates:			cedent of H pecify Cuba 2 X No	spanic Origin? (5 n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	Black, V	American Indian, White, etc. White
1215-0	within 72 ho iene. then "natur the Wedical.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+	}	Decedent's U: (Give kind of life. DO NOT Machin	work done d use retired	ation furing most of wo	rking	16b. Kind of Busin	·
Maryland 21215-0036	should be filed ind Mental Hygid marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last) Joseph Schmitt					Elizabe	me (First, Middle, i th Kapta:	Maiden Sumame) in	
	and 2 shealth and n 27 le n		19a. Informant's Name/Relationship (Typ Helen C. Schmitt (W		71	Yew R	d. Ba		Md. 2122	; City or Town, Sta 21	te, Zip Code)
Baltimore,	Pages 1 nent of H ant: If iter ary or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State		, crematory o	r other plac			20c. Location - City Baltimo	or Town, State
Balti	permit. Departm Importe eny inju		21. Signature of Funeral Service License	vikous	ke	22. Name Bru 140	and Addres zdzins 7 Old	s of Facility Ski Fune Eastern	ral Home Avenue H	P.A. Essex, Md	
- B	Physician /Medical Examiner		23a. Pan 1: Enter the disease, or complic stock, or heart failure. List only one Imm late Cause (Final disease or condition resulting in death)	ations that caused to cause on each line A c J to Due to (or as a	e Mye	eloid		y, such as cardia u Kemi o		est,	Approximate Interval Between Onset and Death
8,60%	icate be executed physician and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, feating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a							
O. Box 68	The law requires that the death certifical te has been signed by the attending phyage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 19 gonths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown	Fetal death	3 □Ectopic 5 □ Other (23d. Date of Month	delivery Day Year
rds, P	w requires that been signed b should be deta	ρ	Part II. Other significant conditions cont	ributing to death but	not resulting in	the underlying	cause give	n in Part I.			e to the cause of death? Probably 4 Munknown
al Kecords,		Completed							24a. Was ar autops perform 1 Yes 2	y prior ned? death	autopsy findings available to completion of cause of 1? Yes 2 \(\sum \) No
VItal		o Be	25. Was case referred to medical examiner? 1 Yes 2 XNo	spital:	2 ☐ ER/Out	patient 3□ [OCA Othe		ath Check only on	nce 6 □Other (S	Procify)
C	fter	atlon: T	27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day)	28b. Tir		28c. Injury Work	at	28d. Describe ho		респу
DIVISION		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	(Specify)				City or Town	, State)	Rural Route Number,
	ne Hospitel or n 24 hours afte ne Funeral Dir oletely filled in	Medicai	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine	cian: To the best of er: On the basis of e and manner state	xamination and/	death occurre for investigation	d at the tim on, in my op	e, date and place inion, death occu	, and due to the ca rred at the time, da	use(s) and manner ite and place, and o	r as stated. due to the cause(s)
	To the within To the compl	Σ	29b. Signature and title of certifier)			9c. License			d. Date signed (Me	
	5+1		30. Name and address of person who com			ype, Print)		52391	10 1	anuary	10, 2004
	Sta	te	Mark Levis 165 31. Date filed (Month, Day, Year)	32. Registrar		treet	Galt	: More,	Mary lar	121231	
	Registr	ar	JAN 1 5 2004	Lis selloss	12	frail.	- fee				

ORIGINAL

	State of Maryland / Department of Health and Menta 1- Registrer For State Certificate of Death	
Physician /Medical	1. Decedent's Name (First, Middle, Last) Charles Paul Schissler 2. Date Mor	UAM 12 2004 10: 29 AM
Funeral Director	4a. Fecility Name (If not institution, give street and number) FCANKLING HOSPITAL Conter 5. Social Security Number 6. Sex 1	v 4c. County of Death BACHIMCTE of Birth nth, Day, Year) 08,1916 9. Birthplace (State or Foreign Country) Maryland
Charles Maryland ath with the Maryland 123s or 28s-1 show mat be notified at real Director	10a. State 10b. County 10c. City, Town or Location MD Baltimore Parkville	10d. Inside City Limits 1 ☐ Yes 2 ◯XNo
Sy CLAP	10e. Street and Number 10f. Zip Code 21234	10g. Citizen of What Country? U. S. A.
9 2 9	11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 1 □ Never Married 2 ☑ Married 1 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 ☑ Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et al., which is the property of the pro	s or No- ttc.) 14. Race - American Indian, Black, White, etc. Specify: White
72 ho 72 ho leted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Be set I	12 Advertisment Department 17. Father's Name (First, Middle, Last) William Phillip Schissler Advertisment Department 18. Mother's Name (First, Barbara Kr	
Mar and 2 sho saith and n 27 is m ar traum	19a. Informant's Name/Relationship (Type, Print) Mrs. Barbara Isaac Daughter 19b. Mailing Address (Street and Number or Rural Route 131 Conley Drive, Annapoli	s, MD. 21403
Page Ment of ury or ury or	20a. Method of Disposition 12 Gremation 3 Removal from State 20b. Place of Disposition (Name of cemetary, crematory of other place) 20c. Place of Disposition (Name of cemetary, crematory of other place) 20c. Place of Disposition (Name of cemetary)	20c. Location - City or Town, State 4 Woodlawn, Maryland yers Funeral Directors, Inc.
be executed with transit burial-transit all Examiner	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respire speck, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	atory arrest, Approximate Interval Between Anset and Death
P.O. Box 687 that the death certificate of by the attending physiciate of to use as the object of the attending physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23d. Date of delivery Month Day Year
Il Records, P The law requires that ale has been signed t page 2 should be det	Part II. Other significant conditions continuous to death out not resoluting in the underlying cause given in a data.	a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of
f Vital Rec nysician: The law is certificate has director, page 2.9	25. Was case referred to medical 26. Place of Death (Chec	performed? death? Yes 2 No 1 Yes 2 No
on o iing Ph After th funeral	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5	Residence 6 Other (Specify) scribe how injury occurred
	3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due	
To the Hosp within 24 hours To the Func completely fil	Table 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	29d. Date signed (Month, Day, Year)
State Registrar	31. Date filed (Month, Day, Year) 22. Registrar's Signature	12 Balance (12, 2004
DHMH 17 Rev 1/2001		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2004 Month **Physician** 10:30 A^M 14, Joseph Shane Jan. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 1006 Concordia Dr. Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Oct. 8, 1913 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1X1M 2□ F 90 197-01-4297 PA Director Usual Residence of Decedent death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene.

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinant must be notified at 1 ☐ Yes 2 No Director Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1006 Concordia Dr. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 X Yes 2 □ No Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 N/A Clerk Post Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Shane Mary Fauser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Shane/Wife 1006 Concordia Dr. Towson, MD 21286 20b. Place of Disposition (Name of cemetery, crematory of other place)
Sunset Memorial Park Jan. 20, 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of
Importent: If it
any injury or o 1 ☐ Bunal 2 ☐ Cremation 3 X Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Philadelphia, PA 21. Signature of Funeral Services sicensee

Pichael J. Flagle Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Road Timonium, MD 21093 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ARDIAC ARREST disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ATHEROSCHIEROTIC CARDINASCULAR DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): physician and s the burial-transit DEPENDENT INSULIN that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Day 4 Pregnant at time of death 5 Other (specify) signed by the al 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CANCER HYPOTHYROIDISM PROSTATE 1 Yes 2 No 3 Probably 4 Honknown 24b. Were autopsy findings available prior to completion of cause of death? OSTEOPORUSIS 24a. Was an certificate has b lirector, page 2 sl autopsy performed? 1 Yes 2 No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 🗆 Nursing Home 1 Yes 2 No ၉ 2 ER/Outpatient 3□ DOA 5 Residence 6 □Other (Specify) this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification; 1 Natural 5 Pending 2 Accident investigation Director: / 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier, 29c. License number 29d. Date signed (Month, Day, Year) 1-14-04 2002-5134 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RIDGELY AVEH 201, ANNAPOLIS, NO 21401 PRESSE IND CAROL 104 31. Date filed (Month, Day, Year) 38. Registrar's Signature State JAN 1 5 2004 Registrar

		For 1 - State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of H rtificate of L			iene g. No. 200	14 00804
Physic	ian	Decedent's Name (First, Middle,	Last) AM REI	N SM	ITH		2. Date of Death Month		3. Time of Death
/Medi Exami		4a. Facility Name (If not institution,			4b. City, Town, or			4c. County of	Death
Funeral Director		217-09-4362	6. Sex 7. A	ge (In yrs. last birthday, 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.			Birthplace (State or Foreign Country) Maryland
Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Hart	ford	10c. City, Town or L					10d. Inside City Limits 1 ☐ Yes 2 🖾 No
with the 3a or 28	I Dire	10e. Street and Number 8810 Walther B	.vd.		10f. Zip Code 2123	34	10	g. Citizen of Wh	at Country? USA
is 1 and 2 should be filed within 72 hours after death with the Maryland is 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "naturel", or frems 23e or 28e-f show other treumatic event, the Marical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 34Vidowed 4 Divorced	12. Was Decedent Armed Forces ad 1 Yes 25 If Yes, Give Year or Dates:	? No	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes ② No	ispanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		American Indian, White, etc. White
A I A I 3-00.50 ad within 72 hours atl gjene. gjene "naturel", or the Marical Exami	Completed t	15. Decedent (Specify only highest Elementary/Secondary (0-12)	s Education	16a. Dece (Give life.	dent's Usual Occupa kind of work done of DO NOT use retired	durina most of wo	rking	16b. Kind of Busin	ness/Industry
V 255	To Be Cor	11 17. Father's Name (First, Middle, L Lewis August	ast) Amrein	HC	memaker		me (First, Middle, M		
d 2 shouth and M		19a. Informant's Name/Relationsh			ing Address (Street a			V.CO 1990.	
Dattillore, interpretation bernit. Pages 1 and 2 should be file Department of Health and Mental Hy importent: if tiem 27 is marked oth any injury or other treumatic event		Ruth Ann Poole 20a. Method of Disposition 1 XBurial 2 Cremation 4 Donation 5 Other (Sp	3 □Removal from State	20b. Place of Disp cemetery, cre	osition (Name of matory or other place Presbyteri	e)	Date	20c. Location - Ci	ty or Town, State
permit. Pages 1 Department of H Importent: If Ite any injury or ot once.		21. Signature of Feneral Service L			2. Name and Addres MCCOMAS F	uneral I		•	
Physician /Medical Examiner		23a. Part1. Enter the disease, or shock, or hear failure. List of Immediate Cause (Final disease or condition resulting in death)	a.	Indicate the death. Do not entine. A S O O s a consequence of):	ter the mode of dyin	g, such as cardia	c or respiratory arre	est,	Approximate Interval Between Onset and Death
rou, le be executed ysician and e burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disasse of many that initiated events resulting in death) Last	c	s a consequence of):					
death certifice attending points as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of Month	
law requires that the as been signed by the 2 should be detached.	þ	Part II. Other significant condition	ALTERZY	•			4.57	s 2 🔼 No 3	ute to the cause of death? Probably 4 Unknown ore autopsy findings available
The law	Completed						autops:	y prid ned? dea	or to completion of cause of ath? Yes 250 No
OI VILAI I Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 □ Yes 2 □ No	Hospital: 1 ☐ Inpat	ient 2 ☑ ER/Outpatie	nt 3□ DOA Othe	05	ath <i>(Check only one</i>		(Specify)
Jing After	ation; To	27. Manner of Death 1 Natural 5 Pending 2 Accident investig	28a. Date of In (Month, D		of 28c. Injury Worl		28d. Describe ho		
DIVISION TENDOR ATTENDERS	Certification;	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 200. Place of it	njury - At home, farm, st atc. <i>(Specify)</i>	reet, factory, office		28f. Location (Sti City or Town		or Rural Route Number,
To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	ledical (Physician: To the bes examiner: On the basis and manner s	of examination and/or in					
To the within To the comp	ž	29b. Signature and title of certified	> , ^		29c. Licenso				Month, Day, Year)
10		30 Name and address of person v			Deien	21809		JAN 14	,
	tate	31. Date filed (Month, Day, Year)		36 YOUC tranggignature	ns Tim	(0 ~ (0 /	n Mo	21043	
Regis			1 5 2004		Loud	2			

State of Maryland / Department of Health and Mental Hygiene 2 0 0 1 Certificate of Death 2. Date of Death 3. Time of Death 1, Decedent's Name (First, Middle, Last) Day 13, **Physician** JANUARY SNYDER 2004 6:50 AM ABRAHAM /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Deeth **Examiner** Baltimore Towson Saint Joseph Medical Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) SEPT.15,1912 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 91 216-05-7911 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "netural", or items 23a or 28a-1 show event, the Medical Exercine rives be notified at 1 ☐ Yes 2 ☑ No BALTIMORE MD BALTIMORE Direct 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number U.S.A. 21208 814 WOODGLEN PLACE Funeral death 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Yes 2 No 1 ☐ Never Married 2 💢 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: þ WHITE 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12 12 College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If item 27 is marked other thu any injury or other traumatic event, Item 2008. OWNER **HABERDASHERY** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be SNYDER PEARL SWAYMAN ္ပ MORRIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PHILLIP SNYDER / SON 6 MARCIE WOODS COURT - BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State BNAI REUBEN CEMETERY: 1/14/2004 * 4 ☐ Donation 5 ☐ Other (Specify) ROSEDALE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Moua 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Cause (Final disease or condition resulting in death) **Physician** PNEUMONIA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed physicien and the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ò in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) o. detached 9 Unknown 9 Unknown م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 Yes 2 No 3 Probably 4 Unknown RECTAL CARCINOMA Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2**2** No certificate 2 No 1 Yes 1 Yes Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To within 24 hours after death.

To the Funerel Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 4 Thomicide To the Haspitel 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D 24034 30. Name and address of person of completed cause of death (Item 23a) (Type, Print) 1611 USLEK DRIVE TÜMBÜN MAKTLEND

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

32. Registras Signature

			For State Registrar	State of Marylan	•	artment of rtificate of		d Ment	al Hygien	. 200	4 00806
	Physicia /Medic		Decedent's Name (First, Middle, Last) Ida	St	ternhe			Jai	ate of Death onth Da nuary	ay Year	04 18:15 AIM
W.	Examin Funeral Director		4a. Fecility Name (If not institution, give: OSE Manor Nurs 5. Social Security Number 6. Ser	sing Home 7. Age (In yrs.	last birthday)	Ellic		ty Hrs. 8. Da	ate of Birth fonth, Day, Year Y 27, 1	Howar 9.8	
	pu ,	or	Usuel Residence of Decedent 10a. State 10b. County MD HOWA	10c. Cit	y, Town or Lo	ocation UMBIA		11/1	1 279 1.		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th with the A 23e or 28e-i	Funeral Director	10e. Street and Number 5354 FLIGHT FEATH		COL	10f. Zip Code	2104	5	10g. C	itizen of What (
980	be filed within 72 hours after deeth with the Maryland ital Hyglene. d other then "natural", or itams 23a or 28a-f ehow other then "natural" or itams avent, the Medical Examinar must be notified at	Ď	11. Marital Status 1 ☐ Never Mamed 2 ☐ Married 3 🎇 Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 🛱 No		? (Specify Y uerto Rican,	es or No- , etc.)	14. Race - An Black, Wh Specify:	
Maryland 21215-0036		Completed	15. Decedent's Edu (Specify only highest grad	cation le <i>completed)</i> Cotlege (1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire CAL	during most of	working		Kind of Busines	ss/Industry
ıryland		To Be (17. Father's Name (First, Middle, Last) CHARLES 19a. Informant's Name/Relationship (Ty	rpe, Print)		HKIN	ТОВ	Υ	t, Middle, Maide	(UN	OBTAINABLE)
	Health ar Health ar tem 27 is		CHARLES E. STERNH 20a. Method of Disposition 1 1 Straight 2 Cremation 3 ST	EIM / SON	5354	FLIGHT esition (Name of matory or other pla	FEATHER		LUMBIA,		45
Baltimore,	permit. Pages Department of Important: If it eny injury or o		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens	NEV		FIORE CI 2. Name and Addr Sol Le	ess of Facility	'14/20 & Br		INELAWN	1, N.Y. 21208
	Physician /Medical		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Congestiv	e He	eart Fo			lrat Road	- Pike	Synthemate D Interval Between Onset and Death
8760,	te be executed hysician and burial-transit burial-transit	dicai Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (of as a conseq Due to (or as a conseq C. Due to (or as a conseq d.	uence of):						
.O. Box 6	the death certifical y the attending phy iched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	Ideath 3	Ectopic pregnand Other (specify)	су			23d. Date of d Month	elivery Day Year
Records, P	The law requires that the de ate has been signed by the a page 2 should be detached f	þ	Part II. Other significant conditions con	ntributing to death but not res	ulting in the u	nderlying cause g	iven in Part I.	_ 2	3e. Did tobacco	_	to the cause of death? Probably 4 □Unknown
		e Completed	OF Was and referred to a referred					11	4a. Was an autopsy performed? □ Yes 2/2 N	prior to	autopsy findings available completion of cause of
Division of Vital	ing Phys After this uneral di	To B	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	Hospital: 1 Inpatient 2 Inpati	ER/Outpatier 28b. Time of Injury	f 28c. Inju		g Home 5	ck only one) i □ Residence escribe how inju		ecify)
Divis	2 # 12 E	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	y) 			C	ity or Town, Stat	Θ)	Rural Route Number,
1/	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier (Check only one) 12 Certifying Phy 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	tion and/or in	vestigation, in my	opinion, death or	ccurred at t	he time, date an	d place, and du	te to the cause(s)
1			30. Name and address of person who co	completed cause of death (Item	23a) (Type.	Print) Da	6621		Jan	wary 12	3,2004
\$	Sta Registr		Gary Milles, MD 31. Date filed (Month, Day, Year) 1	5 2004 Registre's Signa	hart	forti	ive#	200	, Co	lumbi	a MD 21044

			Please	State of Maryland	/ Depa		lealth and M	lental Hygi	_	4 00807
	Physicia		1. Decedent's Name (First, Middle, Las Michael P	Thor	nas			2. Date of Death Month Januari	Day Yes	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give University of Marc	street and number) Jand Medical Co	enter	4b. City, Town, o	r Location of Death		4c. County of D NOT ap	eath plicable
	Funeral Director		5. Social Security Number 6. Se			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey, HALCH 30, 1	9. 1 988 H	Birthplace (Stete or Foreign Quintry) ARY/And
	how [a]		Usual Residence of Decedent 10a, State 10b. County		Town or Lo					10d. Inside City Limits 12d Yes 2 □ No
:	death with the Maryland ms 23a or 28a-f show	Funeral Director	Maryland WA 10e. Street and Number	BAIT	MUR	10f. Zip Code		10	g. Citizen of What	
	sain wil	erai D	3333 Edmondson	Ave. 12. Was Decedent Ever in U.S.	13	212a		ecify Yes or No-	14. Race - A	mencan Indian,
	inin 72 nours atter death with the Marylan an "natural", or Itams 23a or 28a-f show Wedical Examinat must be notified at	by Fune	11. Marital Status Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes No If Yes, Give Year or Dates:	i i	If Yes, specify Cub.	dispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Black, W	Thite, etc.
5	72 hour natural		15. Decedent's Ed (Specify only highest grav	lucation	16a. Dece	dent's Usual Occup	pation during most of work	rina 1	6b. Kind of Busine	
7	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	`life.	Student	d)			
א כו	al Hygi al other	Be Co	17. Father's Name (First, Middle, Last)			9704-00	1) .	e (First, Middle, M	laiden Sumame)	
ryla I	d Ment marke marke	70	19a. Informant's Name/Relationship (7	Type Print)	19b. Maili	na Address (Street	And Number or Rur		MAS City or Town, State	a. Zip Coda)
M	s 1 and 2 should f Health and Mer Item 27 Is marke other traumatic		4 /		3333	-/ .	n ave. K	SA Himbre	~ /	nd 2/229
<u> </u>	9° = 5		20a. Method of Disposition 1 Burial 2 Cremation 3 C	Removal from State	netery, cre	osition (Name of matory or other pla	CO) 1/16/	/ / 110	Oc. Location - City	
Saltimo	d E E E		 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Liden 		Ment 2	ORINE PAR 2. Name and Addre	iss of Facility ACCACE CRANKIN	Gunes	AL SER	MARYLAND
ŏ	Departi Departi Import any inj once		Maciegy M. C	lelee	-		THE RESERVE OF THE PARTY OF THE			
			23a. Parit, Enter L., disease, or comp show, or hay failure. List only Immediate Cause (Final	plications that caused the death. one cause on each line.	Do not en		ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a conseque	ence of):	neuro	mice			7 mo
	Examiner	er	Securitary list conditions if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conseque	ence of):					15 yes.
	cuted	Examin	that initiated events	c			,			0
	be executed sician and burial-transit	a	resulting in death) Last	Due to (or as a conseque	ance of):					
280	tificate ng phys as the	Redic	IS SENALS.	_ d						
O. Box	it the death certificate by the attending phys tached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnan 1 Live birth 2 Fetal of 4 Pregnant at time of decentions	death 3	☐Ectopic pregnanc☐Other (specify) _	у		23d. Date of Month	delivery Day Year
λ. J	as tha	by Ph	Part II. Other significant conditions	ontributing to death but not resul	ting in the u	anderlying cause gr	ven in Part I.	!		e to the cause of death?
Kecords,			CAUS MOX	18/4812				-		Probably 4 Unknown
	sician: The law certificate has b irector, page 2 st	Completed						24a. Was ar autopsy perform	prior death	autopsy findings available to completion of cause of 1? Yes 2 No
VItal	ician: sertifica ector, p	Be	25. Was case referred to medical examiner?	Hospital:		0#		th (Check only one	9)	
0	g Physis or this coral dir	n: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ≥ inpatient 2 ⊔ E	28b. Time o	III 30 DOA	4 🗀 Nursing no	ome 5 ☐ Resider 28d. Describe ho	nce 6 Other (S w injury occurred	(pecify)
DIVISION	eath. or: After the funer	catio	1 Matural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	1	Injury	M 1 [Yes 2 □No			
Ž	al or Attend after death Director: \ d in by the f	Certification:	4 Homicide determined		ne, farm, st	reet, factory, office		City or Town	eet and Number of State)	Rural Route Number,
	To the Hoeptal or Attending Physicien: within 24 hobts after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical C		ysician: To the best of my knowniner: On the basis of examination and manner stated.						
	vithin 2 To the complet	Med	29b. Signature and title of certifier			29c. Licens	se number	/ 29	d. Date signer (M	onth, Day, Year)
	4		Neil) X	Stoffner 1	M)	DO(2572	4	11/11/04	<i>t</i>
	0		Neu J. Crossmo	THE STATE OF THE S	th G	reene St	reet I	Baltimo	re, Mary	land 21201
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar Signatu	ILO SIL	1 Sports				

				State of Maryland / Department of Health 1 - State		/giene Reg. No. 20	04 00808
				Decedent's Name (First, Middle, Last)	2. Date of D Month	eath Day	3. Time of Death
		Physici /Medio		Margaret Mae Thompson	Januar		4 9:38 A M
		Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location Greater Baltimore Medical Center Towson	or Death		imore
T.		Euporal		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under	or 24 Hrs. 8. Date of B	idh	Birthplace (State or Foreign Country)
1		Funeral Director		215-34-8204 1 M 2 F 89 Yrs. Months Days Hours	Min. (Month, D 08/0	1/1914	Maryland
1		and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
urgure		permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Itams 23a or 28a-1 show any injury or other treumatic event, it is Medical Examment in multiple and once.	tor	Maryland Baltimore Cockeysville			1 ☐ Yes 2 ☐ No
2		th the	Olrec	10e. Street and Number 10f. Zip Code		10g. Citizen of V	Vhat Country?
		ath w	ral	300 International Circle, apt 323 21030		USA	e - American Indian,
3		Itams	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 1 □ Never Married 1 □ Never Married 1 □ Never Married	an, Puerto Rican, etc.)	Blac	ck, White, etc.
<	036	ours af	by	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give A 1 ☐ Yes 2 ☑ No Specify Year or Dates:	y:	Specify	White
2	21215-0036	72 ho natur	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during mo life. DO NOT use retired)	ost of working	16b. Kind of Bu	usiness/Industry
0	121	within ene. then	ршр	Elementary/Secondary (0-12) College (1-4or 5+) 12 Cosmetologist		Bea	11+17
50	d 2	filed Hygid other			her's Name (First, Middl		
\leq	Maryland	uld be Aental rked tic ev	To Be	John L. Wilhelm Ida	a Mae Rig	gins	
2	lary	2 shot and h		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number)	ber or Rural Route Num	ber, City or Town,	State, Zip Code)
4	-	fealth im 27 har tr		Rev. Henry C. Thompson, III 1420 Glendale	Road, Ba		Md. 21239 City or Town, State
1	100	ages 1 ot of the :: If ite		1 □ Burial 2 ☑ Cremation 3 □ Bernoval from State			
)	Baltimore	artme ortant injury		*4 Donation *5 Other (Specify) Bayview Crematory 21. Signature of Funeral Service Licensee (22. Name and Address of Facility			ore, Maryland Home, Inc.
	B	Departiment of the post of the		Sulan Silkens Av			
				23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a shock, or heart failure. List only one cause on each line.	- 1		Approximate Interval Between
	20	Physician		Immediate Cause (Final disease or condition a Gastroin testinal	Bleedi	ne	Onset and Death
		/Medical Examiner		Due to (or as a consequence of):		V	
			e	Sequentially list conditions if any, leading to immediate Due to (or as a consequence of):			
		cuted od ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.			
	760,	ate be executed hysician and the burial-transit	I Ex	resulting in death) Last Due to (or as a consequence of):			
		cate b physic the b	dical				
	Вох 68	leath certificat attending phy I for use as th	√Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant		23d. Da	te of delivery
	m.	that the death cer ed by the attendin detached for use	by Physiclan/Med	on the past 12 months? in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 1 ☐ Yes 2 🖼 No 9 ☐ Unknown		Мо	nth Day Year
	P.O.	at the 1 by th stache	Phys	9 □ Unknown	02- Bid		with the text the second of depth?
		es De pe					ribute to the cause of death? 3 Probably 4 Unknown
	Division of Vital Records,	w requir	Completed		24a. Wa	s an 24b.	Were autopsy findings available
	Re	The lav	ошо		per	formed?	Were autopsy findings available prior to completion of cause of death?
	ita	(G 14	Be C	25. Was case referred to medical 26 Place	ce of Death (Check only		22(10
	Ž <	sir di	၉	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 N	Nursing Home 5 Res		
	ou C	ding P	lon	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 1/2/Natural 5 Pending (Month, Day Yeer) Injury Work?		how injury occuri	red
	/isi	spital or Attanding Physician: ours after death. naral Diractor: After this certific filled in by the funeral director,	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location	(Street and Numb	er or Rural Route Number,
	ă	s after al Dira	Certi	4 ☐ Homicide determined building, etc. (Specify)	City or 10	own, State)	
X		To the Hospital or Attanding Pl within 24 hours after death. To the Funaral Diractor: After th completely filled in by the funera	edical (
1		thin 2 the 1 the 1 mplet	Med	one) and manner stated. 29c. License number 29c. License number		29d. Date signer	d (Month, Day, Year)
		2 ¥ ₹ 8		Dunthia Sociano Mo DATISTA	247	Jan	13 2004
		4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	nia sori	anun	10
	-	0		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C Yn + U 6569 N. Charles St #601 Balkmore Me	0 21204		
		Sta Regist	ate rar	St. Date field (Morris), Day, Total IAN 1 5 7000			
	1.3						

		Please		Int in Black in			•	•	ble.
		For State Registrar	State of h	Maryland / Dep <i>Ce</i>	artment of F rtificate of			- 60	04 00809
		Decedent's Name (First, Middle, Las	st)		Timouto or	Douth	2. Date of Death		3. Time of Death
Physici /Medic		Dorothy V. Traber	ct				Month	Day 3	OU D'DS pm M
Examin		4e. Facility Neme (If not institution, give	street and numbe	ər)	4b. City, Town, o	or Location of Death		4c. County	of Deeth
Funeral		Caton Manor Nursi			Baltimo	T		n/a	
Funeral Director		5. Social Security Number 6. Social Security Number 1	ex □M 2]X]F	Age (In yrs. last birthday, Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year)	Birthplece (State or Foreign Country)
		Usuel Residence of Decedent		04			09/30/19	19]	Maryland
larylan ehow	_	10a. State 10b. County		10c. City, Town or Li	ocation				10d. Inside City Limits
The Ms	Director	Maryland n/a 10e. Street and Number		Baltimo	T				1 M Yes 2 □ No
With with the page 1		3396 Dulaney Stre			10f. Zip Code 21229	.	10		Vhat Country?
The Reference of the Maryland is after death with the Maryland is or theme 23a or 28e-f ehow white matches notified at	Funeral	11. Marital Status	12. Was Deceder Armed Force	nt Ever in U.S. 13.		7 Hispanic Origin? (Speran, Mexican, Puerto F	cify Yes or No-		e - American Indian,
36 after		t Never Married 2 ☐ Married	1 ☐ Yes 2 §	No	1 ☐ Yes 21 No		tican, etc.)	Specify	k, White, etc.
	d by	3 Widowed 4 Divorced	Year or Dates	s:					wille
215-0 (215-0 (thin 72 ho	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of working	g 1	6b. Kind of Bu	siness/Industry
d 2121 filed within Hygiene. other than	mo	Elementary/Secondary (0-12)	College (1-4a	Non	e			None	
ind to the title of the other	Be (17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, M	aiden Sumam	θ)
Maryland 21 2 should be filed w 1 and Mental Hygier 1 e marked other it reumatic event, the	10	Arthur D. Trabert		101 14 11			ude A. F		
Maryland of 2 should be file filth and Mental Hy Z7 le marked oth		19a. Informant's Name/Relationship (7) Ronald H. Wilkens				and Number or Rural			
		20a. Method of Disposition	s / neph	20b. Place of Dispo	PETITIONE position (Name of matory or other place)	Drive, Bel			Z1015 City or Town, Stete
		1 Surial 2 □ Cremation 3 □ 1 □ Cremation 3 □ 1 □ Cremation 3 □ Other (Specify	Removal from State ')	(6		ery 1/16	/04 B	altimo	re, Maryland
Baltimore, permit. Pages 1 as Department of Hea Important: if item eny injury or othe		21. Sonature of Funeral Service Licen	500		2. Name and Addre	see of English			Home, Inc.
m gg = g a		Michael (Snow	\sim 4	107 Wilke	ens Avenue	, Balt:	imore,	Md. 21229
		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	olications that caus one cause on each	line.	. /		-		Approximate Interval Between Onset and Death
Pnysician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a	ere has	0680	war f	Ccicl 9	nt	
Examiner			Due to (or a	as a consequence of):	n's /), seaso	2_		
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to or a	as a consequence of):		, 500,			
ecuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
760, le be executed sician and e burial-transit	cal E)	rossing in dozin) Last	Due to (or a	as a consequence of):					
Box 68760, leath certificate be exattending physician of our use as the burial	edica	•	d						
Box (Bath certification of the second of the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		75			23d. Date	e ol delivery
6 death	sicia	in the past 12 months? 1 ☐ Yes 2 🗹 No		at time of death 5[□Ectopic pregnancy □ Other <i>(specify)</i> _	····		Mor	ith Day Year
P.O.	Phy	9 Unknown					00. 004.44		
ds, iries the signed dibe d	by	Part II. Dther significant conditions of	Sertell	Southor resulting in the u	nderlying cause giv	ren in Part I.			bute to the cause of death? 3 Probably 4 Munknown
Cord w requir been si	Completed						24a. Was an		
I Re	dmo						autopsy	ed? d	Vere autopsy findings available rior to completion of cause of eath?
Vital	BeC	25. Was case referred to medical				26. Place of Death	1 ☐ Yes 2) (Check only one)		☐ Yes 2 18 No
Division of Vital Records, or Attending Physician: The law requires talter death. Director: Alberthis certificate has been signed in by the funeral director, page 2 should be control or the structure of the st	ToE	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 Inpa	itient 2 ER/Outpatier	nt 3□ DOA Oth				r (Specify)
on c Jing P J. After t		27. Menner of Death 1 ☑Natural 5 ☐ Pending		njury 28b. Time o Day Year) Injury	Wor		3d. Describe how	injury occurre	d
isio Ntendi death. ctor: A y the fu	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		njury - At home, farm, str		Yes 2 No	Rf Location /Stre	et and Numbe	r or Rural Route Number,
Div	Certification:	4 Homicide determined	building,	etc. (Specify)	eet, factory, office		City or Town,	State)	r or nural noute Number,
Division of Vital Records, P.O. Box 687 To the Hospitel or Attending Physicien: The law requires that the death certificate within 24 hours after death. within 44 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the	edical C	(Check only 2 Medical Exam	iner: On the basis	st of my knowledge, death of examination and/or in	h occurred at the tir vestigation, in my o	me, date and place, ar pinion, death occurred	nd due to the cau	se(s) and mar	ner as stated.
o the ithin 2 o the ompler	Med	29b. Signatur, anythe of certifier	and manner	siated.	29c. Licens			octor-war col	(Month, Day, Year)
		· Culh oft	tending	HAYS.C. O	. !	05364			
Y)		30. Name and address of person who o	5601	death (Item 23a) (Type,	Print)	Blud =	303 B	altri	142004 me 21239
Sta Registr	te ar	31. Date liled (Month, Day, Year)	5 2004 Regis	ster's Signature	foods.				

			Please 1 - For State Registrar	State of Marylar	nd / Depa		Health and M	Mental Hyg	iene	14 nnain
	Physic		Registrar Decedent's Name (First, Middle, La Rose Etta Taylo		001	incate of	Death	2. Date of Deat Month January	th Day Ye	3. Time of Death
	/Med Exami		4a. Facility Name (If not institution, given Upper Chesapeake		er	4b. City, Town, Bel	or Location of Death		4c. County of D	Death
	Funeral Director		217-24-3659	Sex 7. Age (In yrs.	. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Dec. 13	Year) 9. , 1927 N	Birthplace (State or Foreign Country) Maryland
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Harfo		ity, Town or Lo Bel					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
56	death with the Maryland ms 23a or 28a-f show rmust be rotified at	Funeral Director	10e. Street and Number 1101 Thomas Run	Road		10f. Zip Code 21	015	11	0g. Citizen of What USA	t Country?
# 411059	ĕ 2 2	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:	ŀ	Vas Decedent of f Yes, specify Cub ☐ Yes 25 No	Hispanic Origin? (Spoan, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	Black, W	American Indian, Vhite, etc. White
#	vithin 72 ho	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		(Give		pation during most of world ed)	king	16b. Kind of Busine	
	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours alt Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural", or any injury or other traumatic event, the Medical Evertian once.	To Be Cor	11 17. Father's Name (First, Middle, Last George Carl Reeve		Waitr	ess		ne (First, Middle, Mary Mox		nt
	Mary nd 2 shou alth and N 27 is ma		19a. Informant's Name/Relationship (Harry G. Taylor/S				and Number or Ru Run Road,		-	
40	Baltimore, sermit. Pages 1 are Department of Hea Important: If item any injury or other any injury or otheres.		20a. Method of Disposition 1	Removal from State	cemetery, cren	sition (Name of natory or other pla emorial	Gar. 1-15		20c.Location - City Bel Air,	
111/6	Balti permit. Departi Imports any inju		21. Sig lat re Furt ral Service I ce	insee	M	Name and Addr CCOMAS F W. Bro	uneral Ho	me, P.A. 1 Air. M	D 21014	
: 1815	Prysician /Medical Examiner		23a. Part 1 Entarth disease, or comstruct, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	polications that caused the dear one cause on each line. A cutte 1 Due to (or as a consent to (or a consent to (or a consent to (or a consent to (or a consent to (or a consent to (or a consent to (or a consent to (or a conse	L+ Mic quence of):				400	Approximate Interval Between Onset and Death
707	68760,0 ificate be executed g physician and as the burial-transit	cal	resulting in death) Last	Due to (or as a consect	quence of):					
20	Records, P.O. Box 887 The law requires that the death certificate the has been signed by the attending physoage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of	aldeath 3 [Ectopic pregnanc Other (specify)	ey		23d. Date of Month	delivery Day Year
AYC	rds, P quires that n signed t	þ	Part II. Other significant conditions					23e. Did tob		e to the cause of death? Probably 4 Unknown
7		Completed		Hyj	nerte	cutter		24a. Was ar autops perform 1 🗆 Yes 2	y prior death	e autopsy findings available to completion of cause of n? Yes 2 \(\sumbolear\) No
U	/ita	Be (25. Was case referred to medical examiner?					th (Check only one	9)	
Ros	vision of Vital Revalending Physician: The law reseth. ector: After this certificate has by the tuneral director, page 2	2	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Inpatient 2 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Inju	ry at		ence 6 Other (S	ipecify)
	Division of Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	De Disco of Injuny At h]Yes 2 □No	28f. Location (Str. City or Town		r Rural Route Number,
K	a Hospita 24 hours e Funeral	Medical C	(Check only 2 Medical Exer	hysicien: To the best of my kn miner: On the basis of examin and manner stated.	ation and/or inv	estigation, in my	opinion, death occur	red at the time, da	ate and place, and o	due to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	1122A A-	BAIG	29c. Licen	se number	_ 29	d. Date signed (Mo	onth, Day, Year)
	9		30. Name and address of person who 31. Date filed (Month, June 1997)	completed cause of death (Ite	m 23a) (Турв, Аче	Print) Have	-de 6:	race,	MD	21078
	S Regis	tate trar	31. Date filed (Month, Jan Par) 5	2004 32. Rodintars Sign	aturg	(poli)				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Pauline Joan Testerman 5:00P M 10 2004 January /Medical 4a. Facility Name (If not institution, give street and number) 503 Patapsco Ave 4c. County of Death 4b. City. Town, or Location of Death Examiner Rosedale Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 07-19-1917 5. Social Security Number 214–44–1253 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 27 F Director England Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County r then "natural", or Itema 23e or 28e-f ehow the Medical Examiner must be notified at MD Baltimore Rosedale 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 503 Patapsco Avenue 21237 Great Britian Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes ₹5 No Specify: Specify: White Completed by **¾**Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental H lant: If item 27 is marked other. Sydney Perey Richards Ruby Augusta Hocking 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 503 Patapsco Avenue Rosedale Maryland 21237 Mary Testerman permit. Pages 1 and Department of Health Important: If item 27 eny injury or other tr 900s. 20b. Place of Disposition (Name of cometery, crematory or other place)
Oaklawn Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 1/14/2004 Eastwood 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility Cvach/Rosedale Funeral Home 1211 Chesaco Avenue Rosedale Maryland 21237 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest Immediete Cause (Final Physician ingestive resulting in death) /Medical Due to for as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b autopsy performed? 1 Yes 2 40 To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3□ DOA After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 (Natural 5 Pending s after dea. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral [1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ste312, Bultin Tom Edmondson Franklin 2004 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			1 - For State Registrar	State of M	larylan		artmen rtificat				F	Reg. No.	2004	00812
	Physici /Media		1. Decedent's Name (First, Middle, L Jos eph/		her	6					2. Date of Dea Month	Day / 3	2004	3. Time of Death
	Examir		/	CAL CENT	ER	last birthday)	BAL		MARY	LAND	8. Date of Birtl	7	County of Death	CITY
	Funeral Director		218-28-8215 Usuel Residence of Decedent	1□M 2 Ø F	80	Yrs.	Months		Hours	Min.	(Month, Da) July 29	r, Yeer)	3 <u>Ma</u> :	place (State or Foreign ntry) ryland
	e Marylar Ba-f show	ctor	Maryland N/A		10c. Cit	y,TownorLo Baltin								10d. Inside City Limits 1 Yes 2 No
	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show any njury or other traumatic event, the Medical Examinar must be neitled at once.	Funeral Director	Nest Conway St Marital Status	12. Was Decedent Armed Forces	Ever in U.	.S. 13.1		21201		gin? (Spec	city Yes or No-		U.S.A.A.Bace - Ameri Black, White,	A
5-0036	hours after tural, or l	þ	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's	1 Tyes 2 19 If Yes, Give Year or Dates:	No	16a. Deced	1 ☐ Yes		Specify:				Specify: What	
21215	d within 72 giene. ir than "ne ine Medic	Completed	(Specify only highest g Elementary/Secondary (0-12) 8	College (1-4or	5+)	(Give life. I	kind of word DO NOT us	rk done d se retired,	luring most)	of workin	g			ıp Corp.
Maryland 2	ould be filed Mental Hygis arked other atic event, II	To Be C	17. Father's Name (First, Middle, Las Stephen Lanasa	t)			-		_	rs Name Sina	(First, Middle, Sans	Maiden S		
	1 and 2 sho Health and P em 27 le ma ther trauma		19a. Informant's Name/Relationship Barry Glazer (Pe		.)	1031	South	n Cha		Stre	et, Ba		Town, State, Zip ore, Mai	21200
Baltimore,	Pages 1 Iment of H tant: If ite		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec		0	Place of Dispo emetery, crem view C	natory or o Cremat	ther place	01	L-14-	-04	Ba1t		own, State Maryland
Ball	permit. Pag Department Important: I any njury o		21. Signature of Funeral Service Lic	Jam	M	/ 13	80 E.	Fort	Aver	nue,		ore,	P.A. Marylan	nd 21230
	Enysician /Medical		23a. and 1. Enter the disease, or co shock, or heart failure. List onl mmediate Cause (Final disease or condition resulting in death)									est,	-	Approximate Interval Between Onset and Death
1	Examiner	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. ACC Due to (or a:	a consequ	uence ut).	HER	RT	01	15c.	rse			Years Years
8760,	ate be executed hysician and the burial-transit	ilcai Examiner	Gause (Disease or injury that infliated events resulting in death) Last	c. Due to (or as			M	e 62	レノア	US				,
P.O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Feta	I death 3	Ectopic pro					23	d. Date of delive	ery Day Year
rds, P	quires that in signed b uld be deta	þ	Part II. Other significent conditions	contributing to death	but not resi	ulting in the ur	nderlying ca	ause give	n in Part I.				e contribute to the	he cause of death?
		Completed								_	24a. Was a autops perform	med?	24b. Were auto prior to co death? 1 □ Yes	psy lindings available impletion of cause of
Vital	Physicien: Th this certificate rai director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only or			
of	Phys rr this srai di	: To	1 Yes 2 No 27. Manner of Death	1 Empati		ER/Outpatien 28b. Time of		^	4 Nur		e 5 ☐ Reside 3d. Describe ho		☐Other (Specif	(y)
Division	or Attending I after death. Director: After in by the funer	Certification:	1 Natural 5 Pending 2 Accident investigati 3 Suicide 6 Could not	be 29a Blace of In		Injury	М		?` ′es 2 □ N	lo				I Route Number.
÷	To the Höspital or A within 24 hours after Y to the Funeral Director Completely filled in by		4 Nomicide	building, e	tc. (Specif)	v)	•		e. date and		City or Town	n, State)		
7/	the Hohin 24 h the Fur hpletely	Medicai	(Check only 2 Medical Extended)	miner: On the basis of and manner s	of examina	tion and/or inv	estigation,	in my op	inion, death	occurre	d at the time, d	ate and p	lace, and due to	the cause(s)
	Tot	Σ	29b. Signature and title of certifier	Emily ,	RRO		29c	License	number 540	80	2	9d. Date	signed (Month.	Day, Year) 2004
_	4		30. Name and address of person who	completed cause of	MO	23a) (Type.	Print)	RIN	TA	0200	PL	rce	BAL	2004 TIMORE,
	Sta Registr	-	31. Date filed (McArt Day, Yar)20	04 2. Regist	rar's Signa	ture	de la							

			for State Registrar	State o	f Maryland		artmen rtificat			and Me		giene Reg. No	- 7111	04	008	1.3
F	Physicia	an	1. Decedent's Name (First, Middle	Last) THEODORE	WAIT						2. Date of De Month Januar	Day	, 20Č	ear)4	3. Time of De. 7:31 P	
	/Medic Examin		4a. Facility Name (If not institution.				4b. City,	Town, or	Location o				. County of		7.01	•
	V		Genesis Homewo			·		1tim	ore	24 Hes	C. Data of Bir	1	N/A		(0)-1	/
	uneral irector		5. Social Security Number 215-14-8076	6. Sex 1∭2 M 2□ F	7. Age (In yrs. I	ast birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Dec. 14	$\frac{1}{4}$, Year)	922]	Coun	ece (State or Fo try) Land	oreign
pur	X		Usual Residence of Decedent 10a. State 10b. County			/. Town or Lo	cation							11	0d. Inside City L	imits
Manyla	28a-f ehow	ō	Maryland N/A			Baltimo									1 ∑ Yes 2 (□ No
h the	or 28a	Director	10e. Street and Number			JCL C LIII	10f. Zip	Code				10g. Cit	izen of Wh	at Coun	try?	
ath wit	230 0		329 Broxton Ro						1212				U.S			
filed within 72 hours after death with the Maryland Hvolene.	natural, or items 23e or 28a-1 eho: olical Examinar must be mutiliad at	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Marri 3 □ Widowed 4 □ Divorced	Armed Fo	2 🗌 No		Was Dece If Yes, spe 1 ☐ Yes		spanic Orig n, Mexican Specify:	gin? (Spec i, Puerto R	city Yes or No lican, etc.)	o-	Specify:	Amenc White,	etc.	
2 hour	atural Ical E		15. Decedent	's Education	ANATT	16a. Dece	dent's Usu	al Occupa	ation Juring most	t of workin	a	18b. K	ind of Busin			-,-
Athin 7	A MED	Completed	Elementary/Secondary (0-12)	College (life.	DO NOT u	se retired,)		9	C.	teel :	Indi	otry	
filled v	thart int, to		17. Father's Name (First, Middle, I	2 yea	ars		Ma	nage		er's Name	(First, Middle				istry	
2 should be fifed with	rked o	To Be	William Benja	min Wai	tz					abetł			ydricl			
2 sho	is ma rauma		19a. Informant's Name/Relations		`						Route Numb					
1 and Health	tem 2		Anne N. Waitz 20a. Method of Disposition	(wife	20b. P	329] lace of Dispo	sition (Na	me of			more,		ocation - Ci			
Pages	int: If i		1 X Burial 2 □ Cremation 1 4 □ Donation 5 □ Other (Sp		State	ison Fo	rest. V	etrans	s Cent.	1-21	L-04	Owin	ngs M	ills	, Maryl	and
permit.	Important: If item 27 is marked other than "natural any injury or other traumatic event, tra Medical Esones.		21. Signature of Funeral Service I	icensee luun		M 6	Name a itche 500)	ork	s of Facilit iedef Road	eld Bal	Funera timore	1 Ho , Ma	me, I rylan	nc d 2	1212	
			23a. Pert1. Enter the disease, or shock, or heart failure. List	complications that only one cause on	caused the death	n. Do not en	ter the mo	de of dying	g, such as	cardiac or	respiratory a	irrest,			Approximate Interval Betwee Onset and Dea	en ath
	sician ledical		Immediate Cause (Final disease or condition resulting in death)	a. Due to	(or as a consequence		Ch			-						
	aminer		Construction that the distance	b b	Chron		Abrica	nl	FI	brill	latur	_				
P _e	sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consequent		A		ڪ	~	eatin					
, execute	n and al-tran	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a conseq		meA	me		vacc	acoun					
ate be ev	ohysician and the burial-transit	Ical		d	Seryn	re										
DA OC h certifica	ding ph se as t	/Med	IF FEMALE:	23c. If yes, ou	itcome of pregna	incv							23d. Date	of delive	rv	
the death	been signed by the attending pt should be detached for use as t	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		birth 2 Peta nant at time of d nown		⊒Ectopic p ⊒ Other (s						Month		Day Yea	ar
wrequires that	n signed b ald be deta	þ	Part II. Dther significant condition	15		_	inderlying	cause give	en in Part I.			tobacco Yes 2		ute to th	e cause of deal	1
다 등 5 월	2 2	Completed	tyge	holest.	some.						24a. Was auto perf 1 Yes		prid dea	or to cor ath?	psy findings ava appletion of caus	ailable se of
	certificate rector, pag	BeC	25. Was case referred to medical examiner?							of Death	(Check only		1			
OI VIII Physicien:		2	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 _		ER/Outpatie			4 ()-140		ne 5 Res				")	
ding of	Atter this funeral di	tlon	1 Natural 5 Pendin 2 Accident investig	g (Moi	nth, Day Year)	Injury	M	28c. Injury Work 1 🔲 '	⟨? Yes 2 □			110111111111111111111111111111111111111	ny 00001100	•		
DIVISION Is of a lor Attending		Certification:	3 Suicide 6 Could determ	not be 28e. Plac	e of Injury - At he ding, etc. (Specif		reet, facto	ry, office		2	8f. Location City or To			or Rura	l Route Numbe	r,
Hospital	winin 24 nours are To the Funerel Dir completely filled in	edical (29a. Certifier 1 Certifyir (Check only one)	g Physician: To the	e best of my kno basis of examina nner stated.	wledge, dea tion and/or in	th occurred	dat the time n, in my of	ne, date an pinion, dea	nd place, a ath occurre	nd due to the	cause(s , date an	and manr d place, an	ner as st d due to	ated. the cause(s)	
To the	rithin somple	Mec	29b. Signature and title of certifie		iller stated.			c. License				29d. Da	ate signed (Month,	Day, Year)	
1			· E) Alba		MD			461	•		(112/	_ ,		
	0			who completed cau	se of death (Item	n 23a) (Type N , EV	Print)	v 5	T 6	nite	308	, Bo	elf.	MD	2120	1
	Sta Regist		31. Date filed (Month, Day, Year)	1 5 2004 ³²	Hegistrar's Signa	ature	100	Es.								

			- FUI	artment of Health and Men	tal Hygiene
				ertificate of Death	Reg. No. 4 0 0 0 1 1
	Physici /Medic		1. Decedent's Name (First, Middle, Last) MARGARET V. WILSON	,	Date of Death Month 1/1/04 Year 3. Time of Death 5:15 A. M
	Examin	er	4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			SNOW HILL NURSING HOME	SNOW HILL	WORCESTER
	Funeral Director		5. Social Security Number 196-24-9209 6. Sex 1 M 2 M 2 M 7. Age (In yrs. last birthday 70 Yrs.	Months Days Hours Min. (Date of Birth Month, Day, Year) 1/22/33 9. Birthplace (State or Foreign Country) PHILA, PA
	P .		Usual Residence of Decedent		
	- Marylar a-f ehov	tor	MD WORCESTER 10c. City, Town or L		10d. Inside City Limits 1 ☐ Yes 2 M No
	with the	Director	10e. Street and Number 40 CASTLE DRIVE	10f. Zip Code	10g. Citizen of What Country? USA
	ns 23	era	12 Was Decedent Ever in U.S. 13	21811 Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica	
920	d within 72 hours after death with the Maryland piene. I than "naturel", or Items 23e or 28e-f ehow the Medical Exactine must be notified at	by Funeral	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto Rica 1 ☐ Yes 2 No Specify:	n, etc.) Black, White, etc. Specify: WHITE
21215-0036	in 72 hou n "nature Wedical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
212	d within piene. r than "	E	12 College (1-401 5+)	ASHIER	FOOD MARKET
Maryland	id be filed ental Hygik ked other c event, II	To Be C	17. Father's Name (First, Middle, Last) JOHN TAYLOR		st, Middle, Maiden Sumame) Gallagher
lary	ges 1 and 2 should it of Health and Men if them 27 is marked or other traumatic	F		ling Address (Street and Number or Rural Ro	ute Number, City or Town, State, Zip Code)
2	is 1 and 2 of Health a item 27 Is other trai			CASTLE DR. BERLIN, MI	
nore	Pages 1 nent of H ant: If ite ary or otl		Trimminal 21 (Cremation 31 (Bemoval from State)	position (Name of parties) R & PAUL CEM. 1/7/04	20c. Location - City or Town, State
Baltimore,	permit. Page Department of Important: If any injury or once.		A 0 - 1 - 15 - 10 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	22 Name and Address of Facility	
<u> </u>	88 58		* Kathleen Weber CFSP	Dayid J. Weber Fur 1018. Chester St.	neral Homes PA Baltimore, MD. 21231
	Physician /Medical Examiner phural-transit	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Super-tially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	the Liver, En	
P.O. Box 68760	death certificate e attending phy: ed for use as the	Physiclan/Medical		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
	S P C	ρχ	Part II Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
of Vital Records,	The age	Completed	Caronary artery Dise		24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No
ita	ii iii ii	Be (25. Was case referred to medical examiner?	26. Place of Death (Ch	eck only one)
\$	nysicia nis cert direct	2	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	ent 3□ DOA Other: 4⊠ Nursing Home	5 ☐ Residence 6 ☐ Other (Specify)
	Jing After fune		27. Manner of Death 1 ②Natural 5 □ Pending 2 □ Accident investigation 28a. Date of Injury (Month, Day Year) Injury	of 28c. Injury at 28d. Work? M 1 ☐ Yes 2 ☐ No	Describe how injury occurred
Division	I or Attendi after death Director: A	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		Location (Street and Number or Rural Route Number, City or Town, State)
\ \{\gamma}	Hospita 4 hours Funerel ely filled	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea 2 Medicel Exeminer: On the basis of examination and/or in and manner stated.		
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	7		fregeres M. Dellas han) DZ9505	01-01-2004
		7.6	36. Name and Address of person who completed cause of death (Item 23a) (Type GREGORIO M. BELLOSO, M.D.; 5302	,	LISBURY MD 21801
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature 2014		. ,
			WALL OF THE PARTY AND A SECOND	AND AND AND AND AND AND AND AND AND AND	

ORIGINAL

		•	For State Registrar	State of Marylan		artment of H			iene 99. No. 2001	00815
-873			Decedent's Name (First, Middle, Last	t)				2. Date of Deat Month		3. Time of Death
	Physici /Medic		Elmer James Whi					JANUARO	18. 2004	1050 PM
	Examin	er	4a. Facility Name (If not institution, give	street and number)	-	4b. City, Town, or	Location of Death	,	4c. County of Dea	th
47"	Funeral	=======	5. Social Security Number 6. S		last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bir	thplece (State or Foreign
	Director		266-32-2682	ØM 2□F 74	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Feb. 4,	1929 Mai	ountry) Cyland
	and		Usual Residence of Decedent 10a, State 10b, County	10c. City	y, Town or Lo	cation				10d. Inside City Limits
	Maryl -f sho	ţō	Maryland Baltimo	re Ca	tonsvi	11e				1 ☐ Yes 2 XNo
	th the	lrec	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What C	ountry?
	ath wi	rai	820 Fairway Avenu			21228			United Sta	
36	2 should be liled within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itams 23a or 28e-f show aumatic event, the Medical Examinating the notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates;		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2X No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
Ö	2 hou	ted	15. Decedent's Ed	ucation	16a, Deced	dent's Usual Occupa	ation	rina	16b. Kind of Business	
21	Athin 7	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retired,)	9 M	aryland Hi	
2	filed v Hygie other ti	S	17. Father's Name (First, Middle, Last)	4+	CIVII	Engineer		e (First, Middle, M		stration
Maryland 21215-0036	should be ind Mental marked o umatic eve	To Be	Elmer James Whit	e, Sr.			Belle M		,	
lary	2 shou and N is mar	¥0 3	19a. Informant's Name/Relationship (7	• • • • • • • • • • • • • • • • • • • •	1				City or Town, State,	7.6
	and tealth im 27		Mrs. Nancy White		and the second second second second second	Fairway A		the latest and the same of the	le, Maryla	
altimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke any injury or other traumatic.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State Ra1	emetery, crer	matory or other place ish. Crem.	g)		20c. Location - City or aure1, Man	
틅	nat. P.	1	*4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen	7			i i			
മ്	Per Per Per Per Per Per Per Per Per Per		May May	M008	869 16	tzke Fune 30 Edmond	ral Home son Aven	of Cator ue; Cator	nsville, I nsville, M	nc. aryland 2122
			23a Part 1. Enter the disease, or company shock, or leart failure. List only	lications that caused the death						Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Ψ.		TL INF	FARCTIO	~		30 minute
۵	Examiner			Due to (or as a consequ	uence of):	ART	7000	N188	ASE	1747
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ		1/1-1	KACI	0,00,	//	C PER NOW
	and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
8760,	be executed sician and burial-transit		Todaling in obalin, East	Due to (or as a consequ	Jence of):					
687	ate hys	edicai		d						
Вох	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1□Live birth 2□Fetal		Ectopic pregnancy			23d. Date of de	,
E	ne dea the at thed fo	ysici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of de 9☐ Unknown	eath 5⊡	Other (specify)			Month	Day Year
o.	requires that the de neen signed by the a hould be detached t	y Ph	Part If. Other significent conditions of	ontributing to death but not resu	ulting in the ur	nderlying cause give	on in Part I.	23e. Did tob	acco use contribute to	the cause of death?
Division of Vital Records,	w requires been sign should be	ed by						1 ☐ Ye	s 2□No 3□Pi	robably 4 Dunknown
ဓင္ပဝ	aw is b	Completed						24a. Was an autopsy	/ prior to	utopsy findings available completion of cause of
<u>~</u>	Th ate pag	Con						perform 1 ☐ Yes 2	ned? death?	2 No
=	Physicion: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t DOA Othe	c	h (Check only one		
o	Attending Physicien: r death. ector: After this certific by the funeral director,	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury			28d. Describe ho	nce 6 □Other <i>(Spe</i> w injury occurred	city)
jo	ending F sath. or: After he funer	atio	1 Natural 5 Pending 2 Accident Investigation		mjury		res 2 □ No			
Ž	F 8 F 5	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		eet, factory, office		28f. Location (Str. City or Town,	eet and Number or Ri , State)	ural Route Number,
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in		29a. Certifier 12 Certifying Ph	ysicien: To the best of my know	wledge, death	occurred at the tim	e, date and place,	and due to the ca	use(s) and manner as	s stated.
	the Ho in 24 I the Fu ipletely	edical	(Check only 2 Medical Examone)	siner: On the basis of examinat and manner stated.	tion and/or inv	vestigation, in my op	pinion, death occur	red at the time, da	te and place, and due	to the cause(s)
	with To	Σ	29b. Signature and title of certifies	mi		29c. License			d. Date signed (Mont	
,	41		30. Name and address of person who	completed cause of death (from	23a) (Type	Print)	0 3/36	, 3	Stavas	771202E
(011		CHARL	·		57 B	CNB3 1	1050178	n Bre	TIMORE
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signal	ture					
100			JAN J D COUT	- C. C. C. C. C. C. C. C. C. C. C. C. C.		84				

RJ	ſ	•	1 - For Amended Literal Barrier Amende Literal Barrier Amende Literal Barrier	State o	f Marylan	nd / Depj 3/1900	estroent dificate	tas of L	ealth a D <i>eath</i>	nd M		giene Reg. No.	2004	00816
ı	Physici	an	1. Decedent's Name (First, Middle, Las)					2. Date of De Month Januar	Dey	Year 2004	3. Time of Death 0610 P. M
	/Medic Examir		4a. Fecility Name (If not institution, give	street and nur	nber)		,	Town, or	Location of	Death	bandal		County of Death	
ķ	Funeral Director		220-30-3700	X MM 2□F	7. Age (In yrs. 60	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da 08/01)	iy, Year)	Cou	nplace (State or Foreign Intry) Land
	Maryland a-f show	tor	Usual Residence of Decedent			ty.TownorLo								10d. Inside City Limits 1
	with the	Direc	10e. Street and Number				10f. Zip		-				zen of What Cou	untry?
20	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28s-f show or other treumstic event, the Mudical Examinational Benchind at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		2 📉 No /e			rfy Cuba	ispanic Orig	jin? (Spe , Puerto f	city Yes or No Rican, etc.)	U.S.	14. Race - Amer Black, White Specify: Bla	e, etc.
21213-0030	ithin 72 hourse.	Completed b	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation		(Give	dent's Usua kind of wor DO NOT us	k done d e retired	during most I)				ind of Business/I	•
N	ould be filed wi Mental Hygien arkad other th	o Be Cor	17. Father's Name (First, Middle, Last) William Williams			Paint	Remo	val	18. Mother	r's Name	an <i>(First, Middle</i> Lliams		Paint Co Sumame)	mpany
Maryland	h and Men h and Men remarka	P	19a. Informant's Name/Relationship (1	_		0.000.000	0.000000	CHINA CO	and Numbe	r or Rura	l Route Numb		r Town, State, Z	
lore, r	Pages 1 and 3 nent of Health int: If item 27 iry or other tri		Emma Williams / W 20a. Method of Disposition 1 Burial 2 Cermation 3	Removal from	State	Place of Dispo cemetery, crea	osition (Nam matory or ot	ne of ther plac	e)	D	ate	20c. Lo	aryland cation - City or 1	
baitimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		21. Signature of Funeral Service Licen		rie	2:	2. Name and	d Addres	ss of Fac	ae De	errick	C. J	ones F/	
	Physician		23a. Part 1 Enter the disease, or com shook, or heart failure. List only Immediate Cause (Final disease or condition	olications that cone cause on a	each line.	1.							dises	Approximate Interval Between Onset and Death
	/Medical Examiner	_	resulting in death) Sequentially list conditions,	ь	(or as a consec					0.5				
8/60,	ate be executed thysician and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a consec								·	
BOX 6	he death certific the attending p	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live I	tcome of pregn birth 2 Feta nant at time of a	al death 3	⊒Ectopic pro		,				23d. Date of deli Month	very Day Year
ds, P.O	de de	by	Part II. Other significant conditions of Chronic Lead Exposure	_	leath but not res	sulting in the t	anderlying ca	ause giv	en in Part I.			tobacco i		the cause of death?
Hecords,	The law requires ate has been sign page 2 should be	Completed									24a. Was auto pent 1 X Yes		death?	topsy findings available completion of cause of
Vital	Physician: rthis certific ral director.	Be	25. Was case referred to medical examiner?	Hospital:		2		Oth	ar.		(Check only			
ō	ding h. After tune	tion: To	1 Xes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date (Mor	-	28b. Time of Injury		8c. Injur Wor	y at	2	ne 5∐Res 28d. Describe		6 ☐Other (Spec ry occurred	ity)
Division	i Die	Certification:	3 Suicide 6 Could not b 4 Homicide determined	286. Place	e of Injury - At h ling, etc. (Speci		reet, factory	, office		2	28f. Location City or To			ral Route Number,
7	To the Hospitel or within 24 hours affer To the Funeral Dir completely filled in	Medical	29a. Certifier 1 Certifying Ph (Check only 2 Madical Exar	niner: On the b	e best of my kn pasis of examin nner stated.	iowledge, dea ation and/or in	th occurred a nvestigation,	at the tir , in my o	ne, date an pinion, deat	d place, a th occurre	and due to the ed at the time	cause(s date and	and manner as d place, and due	stated. to the cause(s)
V	To th within To th compl	Me	29b. Signature and title of certifier	Londo	-Poll	de en	10		e number .M.E.			Janı	te signed <i>(Montt</i> uary 9,	2004
	5	,	30. Name and address of person who	completed cau	se of death (Ite	m 23a) (Туре	Print)	Per	n Sta	œet,	Balti	more	, Maryl	and 21201
	St	ate	31. Date filed (Month, Day, Year)	5 2004	Registra s Sign	nature	Rea	. 20 0						

State of Maryland / Department of Health and Mental Hygiene

_			•	ertificate of Death	Reg. No	2001 0001=
	Dhysini		Decedent's Name (First, Middle, Last)	0.46	2. Dete of Deeth	3. Time of Death
	Physicia /Medic		GERALDINE WILL	ANVIS.	Jan 8	84 11:45 AM
	Examin	er	4e Fecility Neme (If not institution, give street end number)	4b. City, Town, or L		c. County of Deeth
			Genesis Elder Care	Randall		altimore
	Funeral Director		5. Social Security Number 226-44-0468 G. Sex 1 M 2 XF 7. Age (In yrs. lest birthdom) 7. Age (In yrs. lest birthdom) 7. Age (In yrs. lest birthdom) 8. Yrs 1 Usuel Residence of Decedent	Months Dave Hours Min	(Month, Dev. Yeer	9. Birthplace (State or Foreign Country) 936 Virginia
	fand		10e. Stete 10b. County 10c. City, Town or	Locetion		10d. Inside City Limits
	rith the Marylar or 28a-f show be northed at	ector	Md. Baltimo			1 M Yes 2 □ No
	ath with t	Funeral Director	10e. Street end Number 2801 Coldspring Lane	10f. Zip Code 21215	US.	titizen of What Country? A
980	72 hours effer death with the Maryland natural', or items 23a or 28a-f show iteal Examinat must be notified at	۾	11. Maritel Status 1 Never Merried 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes, 2 No If Yes, Give Year or Dates:	 Was Decedent of Hispanic Origin? (Spil Yes, specify Cuban, Mexicen, Puerto Yes No Specify: 	pecify Yes or No- p Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
2-0	72 ho	ted B	15. Decedent's Education 16a. De (Specify only highest grede completed) (G.	cedent's Usual Occupation	16b. K	Kind of Business/Industry
Maryland 21215-0036	within than "	Completed	Elementery/Secondary (U-12) College (1-4or 5+)	ve kind of work done during most of work DO NOT use retired) estic Engineer		iv-Ind.
Þ	e filed of Hygi other	BeC	17. Fether's Neme (First, Middle, Last)		e (First, Middle, Maider	Sumame)
/lai	ould be Mentel mrked o	10 0	Alphonso Kennedy	Eva Mae	e VanDegr	ift
lan	2 sho and h			ailing Address (Street and Number or Rui		
≥,′	5 = 7 = 5	- 1		1 Coldspring Lar	111	
Baltimore,	Pege ento rt: ਜੋ		1X Burial 2 Cramation 3 Demouslifrom State Cemetery, C	sposition (Name of rematory or other place) nham Vet.Cem.		ocation - City or Town, State heltenham. Md.
Balt	permit. Pege Department of Important: If any Injury or pace.		21. Signature of Funeral Service Licensee	22. Name and Address of Fecility Tri 912 Third St.NW.	L-State F	/S/Inc.
		\dashv	23a. Pert1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on eech line.			Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition	5		Interval Between Onset and Death
1	Examiner		resulting in death) a. Due to (or es e cons	sequence of):		1
4	Si Sd	ine	DEC:	UBITI.		1
	certificete be executed adding physician and use es the burial-transit	edical Examiner	Sequentially list conditions, if env. leading to immediate	equence of):		
68760,	be ey iician buria	<u>8</u>	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury			
687	artificete ing phys e es the	edic	that initieted events Due to (or as e constresulting in deeth) Lest	equence of):		
Box	5 6 8	S١	d			
m	death cer e attendir ed for use	icia 	Part II. Other significant conditions contributing to death but not resulting in the	underlying source since in Rod I	22h Did tahaasa	
0	es thet the death ce igned by the attendi be deteched for use	by Physician/	Secretary of the segment continuous continuous to death but not resulting in the	underlying cause given in Pert I.	1 Yes 2	use contribute to the cause of death?
S, D	s the	2	SPASIC FORAPLEGIA	DIABETES		THO DETICOLORY SECURIORIS
Records,	law requires thet es been signed b s 2 should be dete	Completed			24a. Wes an autoperformed?	psy 24b. Were autopsy findings available prior to completion of cause of death?
R	The law ste hes page 2	E			1 Tyes 1	-
Vital	delan: The	Be	25. Was case referred to medical examiner?	26. Place of Deat	h (Check only one)	
of V	Physician: r this certific ral director,	2	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat	ient 3 DOA Other: Nursing Ho	me 5 Residence	6 □Other (Specify)
0	ng Pt fter th		27. Manner of Deeth Light Pending 28e. Dete of Injury (Month, Dey Year) 28b. Time Injury Injury	of 28c. Injury at	28d. Describe how injur	
sio	Attending ir death.	cati	2 Accident investigation	M 1 ☐ Yes 2 ☐ No		
Division	al or At s effer of il Direct ed in by	Certification:	4 Homicide determined 28e. Plece of Injury - At home, farm, building, etc. (Specify)	street, factory, office	281. Location (Street en City or Town, Stete	nd Number or Rural Route Number, s)
	To the Hospital or Attending Physician: The I within 24 hours efter death. To the Funeral Director: After this certificate ht completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) Check only one) Check only one) Check only one) Check only one) Medical Examiner: On the basis of examination end/or end menner steted.	eth occurred at the time, date end place, investigation, in my opinion, death occurr	end due to the cause(s) ed at the time, date and	end manner as stated. d place, end due to the cause(s)
	To th To th comp		29b. Signeture end title of certifier	29c. License number	29d. Dat	te signed (Month, Dey, Year)
			Il and	10 . D5231	60 1	1/12/04
•	2		30. Name end eddress of person who completed ceuse of death (Item 23e) (Typ	e, Print) (CUBIZ	Utilens	
	/		1838 GREENE TREE	NO SUITE 3	DO PICE	SUMZ MD 21205
	Stat	е	31. Dete filed (Month, Pay, Year) 32. Registrar's Signature	4 1 .		

DHMH 16 Rev 6/95

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** Month Dey JANWARY 7 1:55Am 4a Fecility Neme (If not institution, give street and number) navies 4c. County of Deeth /Medical 4b. City, Town, or Location of Deeth Examiner Stella Baltimos e mari If Under 1 Year If Under 24 Hrs. B. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Country) 1□M 20 F Months 214-84-6102 Yrs. Director Usuel Residence of Decedent 10a. State 10b. County item 27 is marked other than "natural", or itema 23a or 28a-f show other traumetic event, the Madical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits M Balt Director 1X Yes 2 ☐ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? USA 14. Race - American Indian, Funerai 2365 avette 12 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: 15/ack \$ 3 ☐ Widowed 4 ☐ Divorced naturai'. Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry MANIES Elementary/Secondary (0-12) College (1-4or 5+) permit. Peges 1 end 2 should be filed wi Depertment of Health end Mental Hygien, Important: If frem 27 is merked other tha any fulury or other traumetic event, the page. 2+4 ing 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ۵ larence GROTGRANA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cometery, crematory or other place) Irene Rowell Friend E. La fay ette 21231 20a. Method of Disposition Date 20c. Location - City or Town, State NBurial 2 ☐ Cremation 3 ☐ Removal from State Oshell Gardens 1-14-04 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
West Character Ave
2007 Eastern Ave 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. B4/40-Md. 2123 **Physician** Immediete Cause (Final disease or condition resulting in death) /Medical Cerrical Cance Examiner Due to (or as a consequence ot) Physician/Medical Examiner The law requires thet the death certificete be executed ettending physician end for use es the bunel-trensit Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of) Division of Vital Records, P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by certificate hes been sig lirector, page 2 should t 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was en eutopsy performed? 1 🗆 Yes 2 10 1 ☐ Yes 2 ☐ No or Attending Physicisn: efter death. Be 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 DOther (Specify) NOSPICE Certification: To 1 Yes 2 No After this 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturel 5 Pending n 24 hours efter death.

• Funeral Director: After bletely filled in by the fun 1 □ Yes 2 □ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide Hospital 29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai within 2 To the 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2004 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) Limore

DHMH 16 Rev 6/95

Registrar

31. Dete filed (Month, Day, Year)

JAN 1 5 2004

32. Registrer's Signature

		•	For State Registrar	State o	of Marylar		rtment of H			giene Reg. No. 2	2004	00819
	E		Decedent's Name (First, Middle	, Last)					2. Date of De.	ath Day	Yeer	3. Time of Death
	Physicia /Medic		Helen Zitzer	:					January		2004	12:50p.M
į.	Examin	_	4a. Fecility Name (If not institution	, give street and nu	ımber)		4b. City, Town, or	Location of Death		4c. Co	unty of Death	
			Milinium Healt					ott City			Howard	
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 21 ☐ F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th y, Year)	9. Birth Cou	place (State or Foreign intry)
H	Director		214-03-6637 Usuel Residence of Decedent		90	115.			Oct. 25	5,1913	Mar	yland
	land		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					10d. Inside City Limits
	Mary fied	ţ	Maryland Bal	timore		Cato	onsville					1 ☐ Yes 2X No
	r 28a	Director	10e. Street and Number	CIMOIC		04.0	10f. Zip Code			10g. Citizen	of What Cou	intry?
	h with		1317 Denbright	Road			2122	8		U.	S.A.	
	deati	Funerai	11. Marital Status	12. Was Dec	edent Ever in U	J.S. 13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp	ecry Yes or No	- 14.	Race - Ameri Black, White	
2	d within 72 hours after death with the Maryland plen. Jiens - Than - Instural; or Items 23e or 28e-f show the Madical Examiner rount be notified at	T	1 ☐ Never Married 2 ☐ Marr		2X No		☐ Yes 215 No	Specify:	r noun, oron	Sp	anihe:	
2-00-0	ural',	d by	3Æ Widowed 4 □ Divorced	Year or I							WI	nite
5	natu	Completed	15. Deceden (Specify only highes)	(Give	lent's Usual Occupa kind of work done of OO NOT use retired	during most of work	king	16b. Kind (of Business/Ir	ndustry
V	withir	m d	Elementary/Secondary (0-12)	College	(1-4or 5+)		nemaker	,			Own Ho	ıme
7	be filed ital Hygic od other		17. Father's Name (First, Middle,	Last)		Itol	nemaker	18. Mother's Nam	e (First, Middle,			, mc
0	Q 20 0 6	To Be	Stanley Coope					Elear	or Scot	t		
Maryland 2121	shou mar mar	۲	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailin	g Address (Street a	and Number or Rui	ral Route Numbe	er, City or To	own, State, Zi	p Code)
	12 12 14 15		Richard Zitzer	(Son)		2504	Amber Orc	hard Ct.	West (Odento	n, MD	21113
ē,	s 1 and f Healt Item 2 other	1	20a. Method of Disposition			Place of Dispo	sition (Name of natory or other plac		Date	20c. Locati	ion - City or T	own, State
	Pages nent of nnt: If It iry or o		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		1 State	•		' I	5-2004	Marri	ottsvi	lle, Maryla
saitimore,	permit. Pag Department Important: I eny injury o	1	21. Signature of Funeral Service	Licensee		2 7	Name and Addres	s of Facility eral Hom	e of Car	tonsvi	11e. T	nc.
ם	89 = 29		23a. Part1. Enter he disease, or	RUD		1 10	630 Edmon	idson Ave	nue Cat	onsvil	le, Ma	ryland 21228
8/pn, /	Physician buysician and physician and physician superinger is the partial franchism.	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to	o (or as a conse	quence of):	ptic C	ar CI, c	vasc	echi 1	alsh	Onset and Death Lus 10 years
O. Box og	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 Live	utcome of pregr birth 2 Fet gnant at time of nown	aldeath 3	Ectopic pregnancy			23d	l. Date of delive Month	very Day Year
1	w requires that been signed b should be deta	þ	Part II. Other significant condition	ons contributing to	death but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did t	1		the cause of death?
Records,	The law rec	Completed							24a. Was autop perfo		t4b. Were autoprior to condeath?	opsy findings available ompletion of cause of
Vital		0	25. Was case referred to medica					26. Place of Dea				
>	Q 20 A	O B	examiner? 1 ☐ Yes 2 No	Hospital:	Inpatient 2	☐ ER/Outpatier	t 3 DOA Oth	er: 4 ursing H	ome 5 Resi	dence 6	Other (Speci	ify)
0	ding Ph h. After th funeral	n: T	27. Manner of Death 1 Natural 5 □ Pendir	28a. Date	e of Injury onth, Day Year)	28b. Time of	28c. Injun Worl	y at k?	28d. Describe	how injury o	ccurred	
0	andir. sath. or: Af	atic	2 ☐ Accident investi	gation			M 1 🗆	Yes 2 □No				
Division of	or Attencter death	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 200. Place	ce of Injury - At I ding, etc. (Spec	home, farm, str efy)	eet, factory, office		28f. Location (. City or To		lumber or Aur	al Route Number,
_	urs af							ļ				
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical		ng Physician: To the Examiner: On the and ma								
	o the o the omple	Mec	29b. Signature and title of certifie	A			29c. Licens			29d. Date s	igned (Month,	, Day, Year)
	P > F 0		> /	//		mil	105	2740	2	Jan	1	3,2004
	8		30. Name and address of person	who completed car	use of death (Ite	em 23a) (Type,	Print) Che	one le	rat b	Pols	- uc	3,2004 22/22 g
	Sta Regist		31. Date filed (Month, Day, Year,	N 1 5 200		nature	Louis	7				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2064 uthe /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bel Medical Center b. Sex lar for 7. Age (In yrs. last birthday) 86 Yrs. 8. Date of Birth (Month, Dey, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 28. 1 □ M 2 0 F Days Hours 2. Pensylvenie Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 27 is marked other than "netural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 □Yes 2X No 030 Completed by Funeral Director doewood 00 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21040 106 death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be f Health and Mental item 27 is marked o te a MOVEY ,6626 19a. Informant's Name/Relationship (Type, Frint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 39.2 sattler-20b. Place of Disposition (Name of cemetery, crematory or other place) Tholo 21012 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🖟 Cremation 3 Removal from State * 4 □Donation 5 □ Other (Specify) 27 Time and Address of Facility 21. Signature of Funeral Service Licenses neral Home, any ir Aberdeen, Md 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): da /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unisease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has certificate 1 Yes 2.₩1√0 1 Tes inoma 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA ۵ 1 ☐ Yes 2 ☐ No After this funeral dir 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Mannes of Death 28d. Describe how injury occurred Certification: Naturai 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 30. Name and address of person who comp

31. Date filed (Month, Day, Yeer)

DHMH 17 Rev 1/2001

e of death (Item 23a) (Type, Print)

32. Registrar's Signature

	9		1 - For State Registrar		f Marylar		rtment of H	lealth and M Death	F	eg. No.	04	00821
	Physicia	an	Decedent's Name (First, Middle, Last,						2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al			d Crowe		4h Cihi Taum o	r Location of Death	Jun ucy	4c. County		11:42 A) M
	Examin	er	4a. Facility Name (If not institution, give	street and nu	mb u r)		Elktor			Cec		
	Europel		1 Seminary Lane 5. Social Security Number 6. Securi		7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth			lace (State or Foreign
	Funeral Director			M 2□F	60	Yrs.	Months Days	Hours Min.	(Month, Day SEPT 5,			aware
	2		Usual Residence of Decedent									
	arytar show	_	10a. State 10b. County			ity, Town or Lo	cation				1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	Ba-f	5	Maryland Cecil		E	lkton	T				111	
	with the	E C	10e. Street and Number				10f. Zip Code			l 0g. Citizen of \		
	eath	era	1 Seminary Lane	12 Was Dec	edent Ever in U	IS 13 V	2192]		ecify Yes or No-	Unite	e - Americ	
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural, or items 23a or 28a-f show aumatic event, the Maryland Examinat must be indiffed a	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed For 1 Tyes If Yes, Gir Year or 1	orces? 2 ⊠ No ve		Yes, specify Cub	dispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Specify	ck, White,	etc.
215-0036	2 hou	ed	15. Decedent's Edu	cation		16a. Deced	ent's Usual Occup	pation		16b. Kind of B		
212	hin 72	Completed	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (life. L	kind of work done OO NOT use retire	during most of work d)	ing			
7	giene giene er tha	E O		2		Labo	oratory 7	<u> Pechniciar</u>		DuPont		oany
_	-04	Be (17. Father's Name (First, Middle, Last)					18. Mother's Name			ne)	
<u>ya</u>	ould be Mental Marked o	ဥ	Ollie Edward Cro						y McCrea			
Maryland	12 sh h and 7 Is m traum		19a. Informant's Name/Relationship (T)				•	and Number or Run				
e,	1 and Health em 2 ther		Brenda Krautter/	Sister	20b.	Place of Dispo	sition (Name of	rtan Drive		20c. Location -		
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic events.		1 ☐ Burial 2 ☐ Cremation 3 ☐ F		State R.	cemetery, cren A. Ferr	is a co.	^{сө)} Janua	ary 8,	West Ch	ester	c,
	artme ortani injury	1	* 4 □ Donation 5 □ Other (Specify) 21. Signature of Fyneral Service Licens	-	In	C - 22	. Name and Addre	2004		Pennsyl	vania	1
Ba	Dep de de de de de de de de de de de de de	ļ, ļ	Willy 4 1	1	7	H:	icks Home	e for Fune			/	
			23a. Part1. Enter the disease, or complishock, or heart failure. List only of	cations that	caused the dee	th. Do not ente	er the mode of dyir	ockton Str ng, such as cardiac	or respiratory ari	est,	laryic	Approximate Interval Between
	Physician	S 1	Immediate Cause (Final disease or condition					furction			10	Onset and Death
	/Medical		resulting in death)		(or as a conse		ciel on p	urchisa				mm 1,4/6
	Examiner		Supportingly list over the res	b								
	י ס	Iner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consec	quence of):						
~	ecute and trans	Examiner	that initiated events resulting in death) Last	C	(or as a consec	quence of):						
60,	ficate be executed physician and is the burial-transit	al E		504 10	(01 83 8 001136	querios ory.					16	
58760,	phys s the	edical		d								
_	uires that the death certific signed by the attending p d be detached for use as		IF FEMALE: 23b. Was decedent pregnant		tcome of pregn					23d. Da	te of delive	ery
Вох	death a atter d for	Physician/M	in the past 12 months?	4□Preg	birth 2 ☐ Feto nant at time of o		Ectopic pregnancy Other (specify) _	y 		Мо	nth	Day Year
<u>о</u> .	t the by the achee	hys	9 Unknown	9∐Unkr	nown							
	ss tha gned se del	by P	Part II. Other significant conditions co	ntributing to o		11 /		ven in Part I.			ribute to th	ne cause of death?
ğ	w require been sign should b		Hypertension, D.	abete	5 m.	ellitus	, COT	<u>v </u>	1/Q Y	es 2 No	3 Prob	ably 4 □Unknown
ပ္မ	e law re has be ge 2 shi	ple							24a. Was a	sv l	Were autop	psy findings available impletion of cause of
œ —	The ate h page	Completed							perfor 1 ☐ Yes	med? 200 No	death? 1 🔲 Yes	2□ No
Division of Vital Records,	sician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?	1			011	26. Place of Deat	h (Check only or	18)		
5	hysi this c	မ	12 165 2 140		Inpatient 2		t 3 DOA		ome 5 Resid			"
Z C	ding Phys n. After this funeral di	lo	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a, Date (Mor	of Injury oth, Day Year)	28b. Time of Injury	28c. Injui Woo	rk? Yes 2 □No	280. Describe n	ow injury occur	rea	
Sic	death death stor: , the	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Plac	e of Injury - At h	nome, farm, str	et, factory, office	103 25110	28f. Location (S	treet and Numb	er or Rura	l Route Number.
<u>^</u>	after Direction by	Certification;	4 ☐ Homicide determined		ling, etc. (Spec		501, 1201019, 011100		City or Tow	n, State)		
1	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours atted death. To the Funeral Director: Aller this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	edical C	(Check only 2X Medical Exami	ner: On the i	pasis of examin			me, date and place, opinion, death occur				
	the the the mplet	Med	29b. Signature)and title of certifier	and mar	ner stated.		29c. Licens	se number	5	9d. Date signe	d (Month.)	Dev. Year)
	5. ₩ F 00		11216	1 -			7	+7 11s		2		
	1()		30. Name and address of person who co	ompleted on:	se of death (Ite	m 23a) (Tupe	Print)	5)17		lanuar	70,	2004
	10		It Far bis	~ n	II na na	How	7.1 E1	1kton	40			
	Sta	ite	31. Date filed (Month, Day, Year)	5 2078/	Registra Sign	ature 2	Amark.	8				
	Registr	ar	T NIME	O COAL	Marin Con	4767 W T	W. T. W. W. W. W. W. W. W. W. W. W. W. W. W.					

			1 - For State Registrar	State of Maryland		artment of H			giene 200	. 0082
ı	Physic		Decedent's Name (First, Middle, Last					2. Date of Dea	Dey Yea	M
A Service	/Medi Examir		HELEN J. C 4e. Facility Name (If not institution, give	UNNINGHAM street and number)		4b. City, Town, or	Location of Deet	JANUA1	4c. County of De	
			Chester River			Cheste			Kent	
	Funeral Director		5. Social Security Number 6. Si 184-07-0208 1 Usual Residence of Decedent	7. Age (In yrs. la □ M 2\\ 100		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	May 22	^h , Yeer) 9. E 2 1903 Pe	irthplace (Stete or Foreign Country) ennsylvania
	death with the Maryland ms 23e or 28a-f show Imast Le notified at	Funeral Director	10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	he Mi		MD Kent 10e. Street and Number	Ke	nned	ville				1 ☐ Yes 2 ☑ No
	3e or	٦	29365 Glencoe	RA		10f. Zip Code 21645			10g. Citizen of What (,
	death ems 2	Inera	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	. 13. V	Vas Decedent of His Yes, specify Cubar		pecify Yes or No-	U.S.A.	nerican Indian,
215-0036	within 72 hours after death with the Marylan ene. than "naturel", or Items 23e or 28e-f show the Medical Examurer must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Yes 21/2 No	Specity:	o nican, etc.)	Black, Wh	White
<u>ا</u>	n 72 ho "natur edical	lete	15. Decedent's Ed (Specify only highest gra-		16a. Deced	ent's Usual Occupa kind of work done di OO NOT use retired)	tion uring most of wo	rking	16b. Kind of Busines	s/industry
משקע א	d withi	Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		cretary		1	Book Manufact	urina
	be filled ital Hygi id other event,		17. Father's Name (First, Middle, Last)	-			18. Mother's Nar		Meiden Sumame)	arring
ya	D 9 7 7	10	Charles A. Joh					n McAll		
Mary	s 1 and 2 shou if Health and M Item 27 Is mar other traumat		19a. Informant's Name/Relationship (7						r, City or Town, State,	
ē,	es 1 ar of Hea f Item ? r other		Patricia Biscio 20a. Method of Disposition	20b. Pla	ce of Dispos	GIQQINO! sition (Name of satory or other place			a Park, 20c. Location - City of	
altimore,	Pages nent of ant: If It ury or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State		emation	· 1	3/04	Smyrna,	DE.
Ball	permit. Pages Department of Important: If I eny injury or once.		21. Signifilar, of Funeral Service Com	M005	510 Ga 11	Name and Address 1ena Fui 8 West (neral F	Home of	Stephen	L Schaech
			MU0510 118 West Cross St. Galena, MD. 21635 23a Part 1 There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Interval Between							
	Priysician /Medical	i	Immediate Cause (Final disease or condition resulting in death)	a Cordiac	127	lave				Onset and Death Zucutus
	Examiner			Due to (or as a conseque		. <	-0.5			
-	400	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
n	acuted nd transit	Examiner	that initiated events	С.						
	rate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a conseque	nce of):					
200	certificate Iding physi	edicai		d						
×	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No	23c. If yes, outcome of pregnand 1□Live birth 2□Fetal d 4□Pregnant at time of dea	eath 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
5	nat the d by th etache	Phys	9 Unknown	9□ Unknown						
ecords,	equires these sen signer	Completed by	Part II. Other significant conditions co	ictore; Hxf	FODING	stron;		23e. Did tot		to the cause of death?
ב ב	e law has b	mple	Cordino Vilvulz	IV DISCASE; H	XTH	7; HTI)	24a. Was a autops	y prior to	utopsy findings available completion of cause of
VIII I	in: Th fficate or, pag	e Co	25. Was case referred to medical						2 1 □ Ye	s 2□No
Phys.	ysicia is cert directo	0 8	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ EF	NOutpatient	Other		th <i>(Check only on</i>		aciful
	ng Ph fter th	Du: T	1 Yes 2 No						ony)	
10121	ttendli Jeath. tor: A the fu	cath	2 Accident investigation 3 Suicide 6 Could not be			M 1 □ Y€	es 2□No			
2	urs after (rel Direc lled in by	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	the Hosp iin 24 hou the Fune ipletely fi	ledical	one)	sician: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death n and/or inve	occurred at the time estigation, in my opin	, date and place, nion, death occur	and due to the ca red at the time, da	iuse(s) and manner a ate and place, and du	s stated. e to the cause(s)
	To To Con	Σ	29b. Signature and title of certifier	D. On		29c. License		29	od. Date signed (Mon.	th, Day, Year)
	1		30. Name and address of person who co	ompleted cause of death (tem 3	3a) (Tuna 17	D 50			18/04	
	4		Weil Stodda	A M.D 10	OBVE	ocon St.	Closta	rtown	MD Z	1620
	Sta Registra		31. Date filed (Month, Day, Year) JAN 1	32. Registrar's Signatur 5 2004	0	books				

0103		Please Type of Frint in Black ind			-	M. C. C. C. C.		
	4	State of Maryland / Depar	rtment of Health and M tificate of Death		L. V V V	00823		
		Registrar 1. Decedent's Name (First, Middle, Last)	ilicate of Death	2. Date of Death	g. No.	3. Time of Death		
Physicia	_			January	^{Day} 4, 2004	3:00 PM		
/Medica	100	GORDON DUVALL DOWNING la. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	7	4c. County of Death			
Examine	#1 (p)	17309 Tanyard Road	Upper Marlboro		Prince (George's		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birth	place (State or Foreign untry)		
Director	<u> </u>	17-32-4634 ¹ XM 2□ F 67 Yrs.		JAN.16	,1936WASI	INGTON, DC		
and and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	ation			10d. Inside City Limits		
Many -1 sho	ō M	ARYLAND PRINCE GEORGE'S UPPER	MARLBORO			1 ☐ Yes 2 🔀 No		
ith the Marylar or 28a-f show	Directo	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	untry?		
th with	aD	17309 TANYARD ROAD	20772		U.S.A	•		
ems erra	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. W	as Decedent of Hispanic Origin? (Spo Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White			
s afte	by F.	1 Never Married 22 Married 1 Text s 2 No If Yes, Give 1 Year or Dates:	☐ Yes 2 🗓 No Specify:		Specify: WH	ITE		
illed within 72 hours after death with the Maryland Hygiene. Hygiene "naturel", or Items 23e or 28e-f show ent, the Madical Examinat results indiffed at		15 Decedent's Education 16a. Decede	ent's Usual Occupation	1	6b. Kind of Business/I			
n n 72	Completed	(Specify only highest grade completed) (Give k	and of work done during most of work O NOT use retired)	ing				
filed with Hygiene. other than	E	12 FA	RMER		FARMING	}		
be file be file od oth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name					
and yianing & 2 should be filed and Mental Hygins marked other aumatic event, I	ဂ္ဂ	ROBERT RYON DOWNING	GNES DUVALL					
I E, INICILIY INICILIA Z 1 Z 1 Z 1 Z 2 Z 2 Z 2 Z 2 Z 2 Z 3 Z 3 Z 3 Z 3 Z 3	1	, , , , , ,	Address (Street and Number or Rura			- 1		
ges 1 and 3 tof Health If item 27 or other tr	-	20a Method of Disposition 20b. Place of Dispos			Oc. Location - City or 1			
	И	1 Burial 2 Cremation 3 Removal from State	atory or other place) N CREMATORY 1-	7 04 3	ALEXANDR I	7 77 7		
글 교문원들 :	1	TIB INC. OBT III	Name and Address of Facility	7-04	ALEXANDRI	A, VA•		
Depa Impo Bny ii		Markey O O R	AYMOND FUNERAL					
· · · · · · · · · · · · · · · · · · ·		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.		or respiratory arre	st,	Approximate Interval Between		
Physician		Immediate Cause (Final disease or condition a. Carket Guishet would to head Onset and Death						
/Medical Examiner		resulting in death) Due to (or as a consequence of):						
Examiner	_	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):						
bed list	niner	cause. Enter Underlying Cause (Disease or injury						
executed an and rial-transit	Examin	that initiated events c						
sicis	cal	d						
Wrequires that the death certificate been signed by the attending phys should be detached for use as the	Physician/Medi	IF FEMALE:						
ath cer attendir		23b. Was decedent pregnant 1 Live birth 2 Fetal death 3	Ectopic pregnancy		23d. Date of deli Month	very Day Year		
	/sici	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Unknown	Other (specify)					
law requires that the as been signed by the should be detach		Part II. Other significant conditions contributing to death but not resulting in the un-	derlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?		
dS, uires uires ld be	d by			1 □ Ye	s 2.XNo 3⊟Pro	obably 4 Unknown		
law requires as been sign	Completed			24a. Was an	24b. Were au	topsy findings available		
The la	omp			autopsy perform	ed? death?	completion of cause of 2 No		
VII'dl MeC sicien: The law certilicate has b lirector, page 2 s	Be C	25. Was case referred to medical examiner?	26. Place of Deat					
Or VIIA Physicien: rthis certific ral director.	10	1 XYes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient			nce 6XXX ther (Spec	eify) At scene		
ding P	iuo i	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury 28b. Time of Injury (Month, Day Year)	Work?	28d. Describe ho	w injury occurred	4_		
VISION Attending or death. rector: Alte by the fune	icat	2 Accident investigation Found 114 54 Femol 214 3 Suicide 6 Could not be absentined elegation and the suicide	3	28f. Location (Str	eet and Number or Ru	ral Route Number,		
lor A after Direction by	Certification:	4 Homicide determined building, etc. (Specity)	,	City or Town	State)	Marlbaro, MD		
spite hours nerel y fillec		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place,	and due to the ca	use(s) and manner as	stated.		
DIVISION OF VITAL IN TO THE HOSPITED OF VITAL TO THE HOSPITED OF Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or invariant manner stated. 2 Medical Examiner: On the basis of examination and/or invariant manner stated.						
To t Com	Σ	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month	n, Uay, Year)		
41		· Zahilloz Ali	O.C.M.E.	Já	nuary 5, 2	2004		
		30. Name and address of person who completed cause of death (Item 23a) (Type, F 2 ABIULIAH ALI	111 Penn Street	. Baltin	ore, Marvl	and 21201		
Sta	te	31 Date filed (Month, Day, Year) 32. Registrat's Signature				ZIZUI		
Registr		JAN 1 5 2084 > See 15	Roseles		,			
			/					

Registrar DHMH 17 Rev 1/2001

Physici	210	Decedent's Name (First, Midd	_	_		_	2. Date of De. Month		3. Time of De	
/Medic		Roger	Lee	Dawsor		Sr.	JANUARY	7,2004	1:09 p	
Examin	ner	4a. Fecility Name (If not institution	-	or)	4b. City, Town, or		ith	4c. County of I		
		30 WEST 1st STR 5. Social Security Number		x 7. Age (In yrs. last birthday		CUMBERLAND If Under 1 Year If Under 24 Hrs.		ALLEGAN	NY Birthplace (State or Fo	
Funeral Director		212-80-0310	1.XM 2□F	42 Yrs.	Months Days	Hours Mir		2, 1961	Country	
yland now	Funeral Director	Usuat Residence of Decedent								
		MD 10b. Count	ocation Iberland	10d. Inside City L 1 X Yes 2{						
		30 West First	Street			10f. Zip Code 21502			4	
		11. Marital Status	nt Ever in U.S. 13.							
or its	Ē	1 ☐ Never Married 2 ☐ Ma	rned 1 ☐ Yes 2 [If Yes, Give	XNo	1 Yes, specify Cuba 1 Yes 2 No	in, Mexican, Pue Specify:	nto Hican, etc.)		White, etc.	
iraf.	d by	3 Widowed 4 Divorce	Year or Dates					Specify:		
l within 72 ho lene. r than "natur the Mudical	Completed	15. Decede (Specify only high	nt's Education est grade completed)	(Give	edent's Usual Occupa e kind of work done o DO NOT use retired	during most of w	orking	16b. Kind of Busin	ness/Industry	
than	dwo	Elementary/Secondary (0-12)	College (1-4d	Painte		,		Local 947	ocal 947 Union	
	Be C	17. Father's Name (First, Middle						Maiden Sumame)		
Mental Mental Arked c	ToB	Albert Daws	on			Mildre	d (Lower	у)		
SPEE		19a Informant's Name/Relation Laurie Dawsor	ship <i>(Type, Print)</i> wife	19b Mail	ing Address (Street a	and Number or F Street	Rural Route Number	er, City or Town, Sta	MD 215	
and lealth m 27 her tr	Ш			20b. Place of Disp			Date			
if ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 Removal from Sta	cemetery cre	uneral Home	e PA	1/11/2004	Cresapto		
rtmen rtant: njury		`4 □Donation 5 □Other (Orcsapic	JVVII 1VI	
perrint. Pages I and a Department of Health a Important: If I lem 27 is eny injury or other training.		21. Signature of Funeral Service	Licensee	MII	2. Nam Scarpet			rland, MD 21	1502	
-		23a. Part1. Ear or the disease, of	or complications that cau	the death. Do not en					Approximate	
		shock, heart failure. Lis	t only one cause on each	i line.					Intervat Betwee Onset and Dea	
hysician /Medical		disease or condition resulting in death)		ONE AND COCAT	WE INTUXICAT	ION				
xaminer			Due to (or a	as a consequence of):						
7.0	-	Sequentially list conditions, b. Due to for as a consequence of :							-	
d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that indiated events c.								
an al	Exa	resulting in death) Last Due to (or as a consequence of):								
E		,								
	cat	3 3	d							
2 2	cat	IF FEMALE:	d						-	
2 8	cat	IF FEMALE: 23b. Was decedent pregnant		2 Fetal death 3	□Ectopic pregnancy			23d. Date of Month	f delivery Day Year	
2 2	cat	IF FEMALE:	1 ☐ Live birth	2 Fetal death 3 at time of death 5	□Ectopic pregnancy					
2 2	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ ∀es 2 □ No	1□Live birth 4□Pregnant 9□Unknown	2 Fetal death 3 at time of death 5	Other (specify)		23a. Did to	Month		
2 2	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1□Live birth 4□Pregnant 9□Unknown	2 Fetal death 3 at time of death 5	Other (specify)		23e. Did to	Month	Day Year	
2 2	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1□Live birth 4□Pregnant 9□Unknown	2 Fetal death 3 at time of death 5	Other (specify)		1 □ Y	Month bbacco use contribut fes 2 \(\int \) an 24b, Were	Day Year	
2 8	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1□Live birth 4□Pregnant 9□Unknown	2 Fetal death 3 at time of death 5	Other (specify)		1 🗆 Y	Month bbacco use contribution fes 2 Xo 3 Telephone an 24b. Wensy prior deat	Day Year te to the cause of death Probably 4 Unkr a autopsy findings avar to completion of cause th?	
2 8	e Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown ions contributing to death	2 Fetal death 3 at time of death 5	Other (specify)	en in Part I.	1 Yas 24a. Was autop perfor	Month bbacco use contribution fes 2	Day Year te to the cause of deatl Probably 4 Unkr e autopsy findings avair to completion of cause	
2 2	Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant condit	1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown ions contributing to death	2 Fetal death 3 at time of death 5	Other (specify)	en in Part I.	1 Nas autop performed 1 Nes autop performed 1 Nes autop performed 1 Nes autop 2 Nes autop	Month bbacco use contribution fes 2 2 40 3 an 24b. Wern prior deat 2 1 No 1 March 1 March 2 1 No 1 March 2 1 No 1 March 2 1 No 1 March 2 1 No 1 March 2 March 2 1 No 1 March 2 March	Day Year Day Year Day Year Day Year Day Year Day Year Day Year Day Year Day Year Day Year Day Year Day Year	
2 2	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condit 25. Was case referred to medical examiner? XXYes 2 No 27. Manner of Death	1Live birth 4Pregnant 9Unknown ions contributing to death Hospital: 1Inpa 28a_Date of In	2 Fetal death 3 at time of death 5	Other (specify) underlying cause give	en in Part I. 26. Place of Deer. 4 □ Nursing	24a. Was autop performed to the control of the cont	Month bbacco use contribution fes 2	Day Year Day Year Day Year Day Year Day Year Day Year Day Year Day Year Day Year Day Year Day Year Day Year	
ing ripscrati. The taw requires that the beath centilicate for this certificate has been signed by the attending phy ineral director, page 2 should be detached for use as the	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	1 Live birth 4 Pregnant 9 Unknown ions contributing to death Hospital: 1 Inpa 28a. Date of Ir fortant: 1	2 Fetal death 3 at time of death 5 street 5	other (specify) underlying cause give nt 3 DOA Other of 28c. Injury Work M 1 DOA	en in Part I. 26. Place of Deer. 4 □ Nursing	24a. Was autop performed to the control of the cont	Month bbacco use contribution fes 2	Day Year Day Year Day Year Day Year Day Year Day Year Day Year Day Year Day Year Day Year Day Year Day Year	
ing ripscrati. The taw requires that the beath centilicate for this certificate has been signed by the attending phy ineral director, page 2 should be detached for use as the	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condit 25. Was case referred to medical examiner? XX es 2 No 27. Manner of Death 1 Naturat 5 Pendicity	ILive birth 4Pregnant 9Unknown ions contributing to death Hospital: 1Inpa 26a. Date of Ir former. 1 1/07/04 28e. Place of I	2 Fetal death 3 at time of death 5	other (specify) underlying cause give	26. Place of Dε 26. Place of Dε 27. 4 Nursing	24a. Was autop performed to the control of the cont	Month bbacco use contribution fes 2	Day Year Day Year Day Year Day Year Day Year Day Year Day Year Day Year Day Year Day Year Day Year Day Year	
ing repairment in the name optimes that the attending phy literal director, page 2 should be detached for use as the	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condit 25. Was case referred to medical examiner? XX es 2 No 27. Manner of Death 1 Naturat	1 Live birth 4 Pregnant 9 Unknown 10 Unknown 10 Inpa 10 Inpa 10 Inpa 10 Inpa 10 Inpa 10 Inpa 10 Inpa 10 Inpa 10 Inpa 10 Inpa Inpa 10 Inpa Inpa 10 Inpa Inpa 10 Inpa	2 Fetal death 3 at time of death 5 t	other (specify) underlying cause give	26. Place of Dε 26. Place of Dε 27. 4 Nursing	24a. Was autop perior 1 Syres Path (Check only of the control of	Month bbacco use contribution fes 2	Day Year Day Year Teautopsy findings avair to completion of cause Per 2 No Specify)	
ing ripscrati. The taw requires that the beath centilicate for this certificate has been signed by the attending phy ineral director, page 2 should be detached for use as the	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	al Hospital: 1 Inpa ggation not be mined 28a. Date of Ir fortinative 28b. Place of building, Ing Physicien: To the besite Exeminer: On the basis	2 Fetal death 3 at time of death 5 shall be at time of dea	other (specify)	26. Place of De 27. 4 □ Nursing 28. Yes ※XXNo	24a. Was autop performent of the control of the con	Month bbacco use contribution fes 2	Day Year Day Year The to the cause of death Probably 4 Unkr The autopsy findings awar The to completion of cause The cause Th	
ing ripscrati. The taw requires that the beath centilicate for this certificate has been signed by the attending phy ineral director, page 2 should be detached for use as the	edical Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	1 Live birth 4 Pregnant 9 Unknown Inna 1 Inna Inna 28a. Date of Information 1/07/04 28e. Place of building, Innat be nined 28e. Place of building. Figure 1 Exeminer: On the basis and manner	2 Fetal death 3 at time of death 5 shall be at time of dea	other (specify) underlying cause give nt 3 DOA Other 28c. Injury Work M 1 To reet, factory, office	26. Place of Dear: 4 □ Nursing at (?) Yes ※XXNo	24a. Was autop performed at the time, of	Month bbacco use contributives 2 No 3 med? an 24b. Wennersy prior deat 2 No 1 Mence 6 Mother (Street and Number of the state) Street and Number of the state and place, and place, and	Day Year Day Year Day Year Te autopsy findings avair To completion of cause The Specify) De Rural Route Number, RIAND ,MD The as stated. The cause(s)	
2 2	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	1 Live birth 4 Pregnant 9 Unknown Inna 1 Inna Inna 28a. Date of Information 1/07/04 28e. Place of building, Innat be nined 28e. Place of building. Figure 1 Exeminer: On the basis and manner	2 Fetal death 3 at time of death 5 shall be at time of dea	other (specify)	26. Place of Deep: 4 Nursing 4 at Yes XXNo	24a. Was autopoperformed at the time, of the course of the	Month bbacco use contribution fes 2	Day Year Day Year Day Year Day Year Day Year Day Year Year Day Probably 4 Unkr Pro	
ing ripscrati. The taw requires that the beath centilicate for this certificate has been signed by the attending phy ineral director, page 2 should be detached for use as the	edical Certification; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	1 Live birth 4 Pregnant 9 Unknown 1 Inpa 1 Inpa 1 Inpa 1 Inpa 1 Inpa 1 Inpa 1 Inpa Inpa 1 Inpa	2 Fetal death 3 at time of death 5 state of death 5 state of death 5 state of death 5 state of death 5 state of death 5 state of examination and/or is stated.	other (specify) underlying cause give not 3 DOA Other 28c. Injury Work M 1 DOA the occurred at the time the time stigation, in my op 29c. License OCME	26. Place of Deep: 4 Nursing 4 at Yes XXNo	24a. Was autopoperformed at the time, of the course of the	Month bbacco use contribution fes 2	Day Year Day Year Day Year Day Year Day Year Day Year Year Day Probably 4 Unkr Pro	

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	1 - For Unpend Item #23a, State Registrar 1. Decedent's Name (First, Middle, Last)				0, 2			2. Date of De.		Yea	3. Time o
ian ical	Sedgrick	Marquez	Enyart					Janu		1, 200	
	4a. Facility Name (If not institution, give s	treet and number)		4b. City,	Town, or	Location o	of Death		4c.	County of D	eeth
31	2546 A Hawthorn W	ay				n Pai		0 D (D):		. Mary	
l r	300-21-3134	M 2□F	(In yrs. last birth		Days	Hours	Min	8. Date of Bird (Month, Da December	y, Year) 10, 1		Birthplece (State Country) Chigan
7 }	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location					-		10d. Inside C
ō	Maryland St. Mary	' s	Lexing	ton Par	k						1 ☐ Yes
Director	10e. Street and Number			10f. Zip	Code				10g. Citiz	zen of What	Country?
Ö	2546A Hawthorn Wa	ıy			20653	3				USA	
Funerai	11. Marital Status	2. Was Decedent E Armed Forces?	ver in U.S.	13. Was Deced	dent of His	spanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)	- 1	14. Race - A Black, W	merican Indian,
E.	1 XNever Married 2 ☐ Married	1 ∐ Yes 2 ZÑN If Yes Give	0	1 ☐ Yes	**	Specify:		, , , , , , , , , , , , , , , , , , , ,	1		Black
d by	3 Widowed 4 Divorced	Year or Dates:								,	
Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(ecedent's Usua Give kind of wor life. DO NOT us	rk done di	uring most	t of work	ing	16b. Kir	nd of Busine	ess/Industry
d L	Elementary/Secondary (0-12)	College (1-4or 5	+)		36 /61/60/						
ပိ	17. Father's Name (First, Middle, Last)					18. Mothe	er's Name	e (First, Middle,	Maiden	Sumame)	
m	Sedgrick Albert 3	Jacob				Jea	annie	Mae Ei	nyart	:	
2	19a. Informant's Name/Relationship (Type		19b. /	Mailing Address	(Street a.	nd Numbe	er or Rura	al Route Numb	er, City or	Town, State	e, Zip Code)
	Jeannie May Coles,	Mother/	254	6A Hawt	horn	Way,	Lex	ington	Park	c, MD	20653
	20a. Method of Disposition		20b. Place of D	Disposition (Nar., crematory or o	ne of other place	9)	(Date	20c. Lo	cation - City	or Town, State
	1 ☐ Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Southern				anuar	y 9, 200	Jack	son, Mi	i c higan
ei	21. Signature of Funeral Septice License	99	,	22. Name an	nd Address	s of Facilit	ty Mat	tingley-	Gardir	er Fund	eral Home,
	1 Kile Sin	menz		P.O.	Box, 2	270, L	eonar	dtown, Ma	arylar	nd 20650	0
10	23a. Part1. Enter the disease, or complications, or heart failure. List only on	cations that caused	the death. Do no	ot enter the mod	le of dying	, such as	cardiac i	or respiratory a	rrest,		Approxima Interval Be
n	Immediate Cause (Final	ACUTE PN									Onset and
al	disease or condition resulting in death)		a consequence of	i):							
r	Description that are divined in)									
ner	Sequentially list conditions, if any, leading to immediate cause. Enter uncerping Cause (Disease or injury		a consequence of	·):							
Examiner	Cause (Disease or injury that initiated events resulting in death) Last			n.							
ŭ	resulting in coality cast	Due to (or as a	a consequence of):							
dicai		l									
/Mec	IF FEMALE:	3c. If yes, outcome	of pregnancy							and Date of	dalaran
Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death	3 ☐Ectopic pr 5 ☐ Other (sc					2	23d. Date of Month	Day
ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	tille of death	3 Ott161 (3)	<i>Jecny</i>)						
	Part II. Other significant conditions con	tributing to death bu	ut not resulting in	the underlying o	ause give	n in Part I	١.	23e. Did t	obacco u	se contribut	e to the cause of
d by	CEREBRAL PALSY							1 🗆	Yes 2	Σπ ₀ 3□	Probably 4
Completed								24a. Was	an	24b. Were	autopsy findings
E D									rmed?	prior	to completion of h?
ပိ	25. Was case referred to medical					oe Plane	o of Deat	1 Yes	2 No	1	Yes 2□No
o Be	examiner?	lospital:	nt 2□ER/Out	patient 3 DC	Othe					S Sether (S	Specify) At s
H	27. Manner of Death	28a, Date of Injur	y 28b. Ti	me of 2	28c. Injury	at	or our grite	28d. Describe			AL S
후	1 X Natural 5 ☐ Pending Investigation	(Month, Da)	/ Year) In	jury M	Work 1 □ \	r Yes 2□	No				
Certification:	3 Suicide 6 Could not be determined		ury - At home, fan	m, street, factor	y, office			28f. Location (City or To	Street an	d Number or	r Rural Route Nui
ert	4 Homicide	building, etc	o. (Specify)					ony or . o	·····, otato,	,	
	29a. Certifier 1 Certifying Phys	sician: To the best	of my knowledge,	death occurred	at the tim	e, date an	nd place,	and due to the	cause(s)	and manne	r as stated.
	(Check only 2 Medical Examinate)	and manner sta	examination and	/or investigation	1, 111 my OF	omion, dea	atti occui	red at the time,	uate and	piace, and	
edical	201 0		/	29	c. License	number			29d. Dat	e signed (M	lonth, Day, Year)
Medic	29b. Signature and title of certifie	/ //		-							
	290. Signature and officer of certifier	1 V t	m	(O.C.M	1.E.			Janu	ary 2	2004

SHANNAN A GOINS 04-00107 DAP **Physicia** /Medic Examine **Funeral** Director permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28s-1 show any injury or other treumatic event, the Medical Examinar must be notified at once. Baltimore, Maryland 21215-0036

> Physician /Medical Examiner

> > attending physicien and for use as the burial-transit

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

within 24 hours after death.

To the Funerel Director: After this certificate has i completely filled in by the funeral director. page 2 s

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 1 1 1

00826

	1 - State Registrar	Ce	ertificate of i	Death		Reg. No.	007	00020
	Decedent's Name (First, Middle, Last)				2. Date of De	aath Day	Yeer	3. Time of Death
n si	SHANNAN ARLENE GOINS					Y 4.200		8: 57 p M
ai er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. Cour	nty of Deeth	
	CIVISTA MEDICAL CENTER		LAPLATA			CHAI	RLES	
	1011	(In yrs. last birthda)	/) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bit (Month, Da	rth ay, Year)	9. Birth	place (Stete or Foreign intry)
	261-91-3146 ^{1□M 2} \\F	35 Yrs.	/		SEPT.	6,1968	8 FLC	RIDA
	Usuat Residence of Decedent 10a. State 10b. County	10c. City, Town or I	ocation					10d. Inside City Limits
ž	14.740	i i i i i i i i i i i i i i i i i i i		DIATMC				1 ☐ Yes 2 ☐ No
ectc	MARYLAND CHARLES		WHITE	PLAINS		10a. Citizen	of What Cou	
	10e. Street and Number 9770 HOPE ACRES ROAD		10f, Zip Code	20695	==		.S.A.	,
rai	Lan W. December 1	Everia II S 12	. Was Decedent of H		acity Yas or No		Race - Amer	
Funeral Director	11. Marital Status 12. Was Decedent CArmed Forces? 1 Never Married 2 Married 1 Yes 2		If Yes, specify Cuba	in, Mexican, Puerto	Rican, etc.)		Black, White	
by	3 Widowed 4 Noivorced Year or Dates:		1 ☐ Yes 2 XNo	Specify:		Spe	city: W	HITE
ed	15. Decedent's Education	16a. Dec	edent's Usual Occup	ation		16b. Kind of	Business/li	ndustry
plet	(Specify only highest grade completed) Elementary/Secondary (0-12) Cotlege (1-4or 5	life	re kind of work done of DO NOT use retired		ing			
Eo	Elementary/Secondary (0-12) Cotlege (1-4or 5		HOMEMAKE	₹		OWI	N HOM	íE
Be Completed	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle	, Maiden Sum	name)	
To B	CHARLES W. GOINS			JEAN	ALICE	LEAR	Y	
_	19a. Informant's Name/Relationship (Type, Print)	19b. Ma:	iling Address (Street	and Number or Run	al Route Numb	er, City or Tov	wn, State, Zi	p Code)
	CHARLES W. GIONS-FATHE	R 650	9 CLAYTO	ON LANE	DR.	SUITL	AND, M	ID.20746
	20a. Method of Disposition	20b. Place of Disposemetery, cr	position (Name of rematory or other place		Date	20c. Locatio	on - City or T	own, State
	1 ☐ Burial 2 ★Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MET	ROPOLITA	N CREMA	TORY 1-1	0-04	ALEXA	ANDRI	A, VIRGINI
	21. Signature of Funeral Service Licensee MOO4	The state of the s	22. Name and Addre	ss of Facility				
	Machand O.D.	1	RAYMOND LA PLAT				• A •	
	23a. Part1 Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lir	the death. Do not e						Approximate Intervat Between
	Immediate Cause (Final	Milti	le injur	185				Onset and Death
	disease or condition resulting in death) a. Due to (or as	a consequence of):	-				_	
er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a consequence of):						
直	Cause. Enter Underlying Cause (Disease or injury that initiated events c.							
Exa		a consequence of):						
cai	d							
Medicai Examiner							and the same of th	
2	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome		B Ectopic pregnancy	,			Date of delin	
icia	1 Yes 2 No		Other (specify)				Month	Day Year
Completed by Physician/	9 AND KNOWN							
by F	Part II. Other significant conditions contributing to death b	ut not resulting in the	underlying cause giv	en in Part I.				the cause of death?
ed					1	Yes 2 No	5 3∐Pro	bably 4 🗀 Unknown
pie					24a. Was	s an 24	prior to c	opsy findings available ompletion of cause of
Eo					perf	ormed? 2 □ No	death?	2 □ No
BeC	25. Was case referred to medical			26. Place of Deat				
0	examiner? 1 X Yes 2 □ No Hospital: 1 □ Inpatie	ent 20 ER/Outpati	ient 3 DOA Ott	er: 4 🗆 Nursing Ho	ome 5 Res	idence 6 🗀	Other (Spec	ify)
L:	27. Manner of Death 1 Natural 5 Pending 28a. Date of Inju	ry 28b. Time		y at k?		how injury occ		:/-
atlc	2 Accident investigation 1/4/04	Found 2		Yes 2 No	Driver of	a Car Co	uicud	with unother vehicle
tific	3 Suicide 6 Could not be determined 28e. Place of Injuding, et	ury - At home, farm, c. (Specify)			28f. Location City or To	(Street and Nu	mber or Ru	ral Route Number, Rd
Cer		str	eet		East of C	slumbic, P.	ork, Chil	reles Co. MD
cai	29a. Certifier (Check only 2 Medicel Exeminer: On the basis o							
Medical Certification: To	one) and manner st	ated.			1.0.0			
2	29b. Signature and title of certifier	la 1	29c. Licens			29d. Date sig		
	296. Signature and title of certifier talkee Mar A	- 1	OCM	Ľ		JANUAR	x 5,2	004

State Registrar 31. Date filed (Month, Day, Year) JAN 1 5 2004 32. Registrar's Signature

30. Name and address of person who completed gause of death (Item 23a) (Type, Print)

245 JUCLAN TILL Penn Street, Baltimore, Maryland 21201

ORIGINAL

			1 - For State Registrar	State of Marylan	•	ent of Health and ate of Death		ene 2004	00827
Г	- 5	30	Decedent's Name (First, Middle, Last,)			2. Date of Death		3. Time of Death
	Physici /Medio		GIRA GE	tchell			January		12:14AM
	Examir	er	4a. Facility Name (If not institution, give			ity, Town, or Location of De	ath	4c. County of Deeth	
	* 2		Greater Baltimon 5. Social Security Number 6. Se.			Towson der 1 Year If Under 24 H	rs. 8. Date of Birth	Baltimo:	
e	Funeral Director			_M 2XF	Yrs. Mont		n. (Month, Day,	Year) Cou	place (State or Foreign ntry)
465	D		Usual Residence of Decedent				- Tricker of		
	arylan show	-	10a. State 10b. County		, Town or Location				10d. Inside City Limits 1 Yes 2 No
	he Mi	Director	MD ANNE A	TRUNDEL GL	EN BUR	NIE Zip Code	10	og. Citizen of What Cou	
	with t	Ö	3079 GIRLEN	ORCHARD A	20: 11	21061		$II \subset \Lambda$	iiuy :
	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28e-f show the Modical Exanites must be notified at	Funeral	11. Marital Status	12. Was Decedent Ever in U.		ecedent of Hispanic Origin? specify Cuban, Mexican, Pue	(Specify Yes or No-	14. Race - Ameri	
9	after or Ite	Fur	1 Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 No If Yes, Give		specify Cuban, Mexican, Pue s 2⊠No <i>Specify:</i>	erto Hican, etc.)	Black, White,	etc.
21215-0036	ural',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	1016	s z a No Specily.			HITE
2	"nata	Completed	15. Decedent's Edu (Specify only highest grad	ucation de completed)	16a. Decedent's l (Give kind of	Jsual Occupation i work done during most of w T use retired)	vorking	6b. Kind of Business/Ir	dustry
12	within lene. than	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		VFANT		INFAN	7
b	be filed ntal Hygie od other	BeC	17. Father's Name (First, Middle, Last)				ame (First, Middle, M		
/lar	should be ind Menta in marked umatic ev	ToE	REED	GETC	HELL	KAR	A GET	CHELL	
Maryland	C1 00 = 00		19a. Informant's Name/Relationship (T)		19b. Mailing Add	ess (Street and Number or	Rural Route Number,	City or Town, State, Zip	Code)
e)	l and lealth im 27	33	NIKKI CHILLOAT	PATHOLOGY	lace of Disposition (Name of	Date 2	Oc. Location - City or To	CIE State
Baltimore,	Pages nent of H		1 ☐ Burial 2 🖫 Cremation 3 ☐ F	Removal from State	emetery, crematory	or other place)	100/04 9	PAD-TAGAS.	AA C
풀	it. Partme		 4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service/Licens 			and Address of Facility	108107	DALO IMOVA	5 + SONS CO
Ba	permit. Depart Import any nj		KATI LON	TAZO	11-97	4 VAZE P	LENKS WON	KTON, MI	
	Physician /Medical Examiner behavioral and brusial-transit sthe purial-transit	Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, any, least 1 immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence to a consequ	1 Defect	ts		F	Interval Between Onset and Death
Ő,	e exe dan ar urial-t		resulting in death) Last	Due to (or as a consequ	uence of):				
8760	cate b	dicai		d					
P.O. Box 6	death certif e attending od for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	death 3 Ectop	c pregnancy (specify)		23d. Date of delive	ery Day Year
	requires that the reen signed by th hould be detache	y Ph	Part II. Other significant conditions co	entributing to death but not resu	ulting in the underlying	ng cause given in Part I.	23e. Did tob	acco use contribute to t	he cause of death?
rds	w requires that been signed to should be det	ed b					1 □ Ye	s 2. Moo 3. Prot	oably 4 Unknown
Division of Vital Records,	The law ate has b page 2 sl	Completed					24a. Was an autopsy perform	prior to co	opsy findings available impletion of cause of
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			eath (Check only one)	
n of	£ € ë	lon: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 28b. Time of Injury M	Other: 4 Nursing 28c. Injury at Work? 1 Yes 2 No	Home 5 Resider	oce 6 Other (Special injury occurred	(y)
isic	or Attending after death. Director: After in by the fune	ertification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At ho	ome, farm, street, fac		28f. Location (Str	eet and Number or Rura	al Route Number,
á	ator A safter I Dire	Certi	4 Homicide	building, etc. (Specif)	v)		City or Town,	State)	
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	edical (29a. Certifier (Check only one) 2 Medical Exam	ysician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, death occur tion and/or investiga	red at the time, date and pla tion, in my opinion, death oc	ce, and due to the ca curred at the time, da	use(s) and manner as s te and place, and due to	stated. the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier			29c. License number	29	d. Date signed (Month,	Day, Year)
1	13		Ellertomann	ND		D00531	01	1/4/04	
4	· U		30. Name and address of person who c	ompleted cause of death (Item	1 23a) (Type, Print)	James	+ Rosen	Ma.	212
		ı te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	A CHAMPES O	VHILLIII	olde I'l II	21204
	Sta Regist		1 1 4 2004	Acolo 18	Rosell)				

DHMH 17 Rev 1/2001

Getchell (Firl A Kam.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 2004 CATHERINE FRANCES HOPKINS JAN. 50 pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CIVISTA MEDICAL CENTER LA PLATA CHARLES If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. CT 1 10, 1927 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign County)
OH IO **Funeral** Months 1 ☐ M 257 F 76 Yrs. 300-32-4196 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic avent, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Funeral Director MARYLAND BEL ALTON CHARLES 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 9503 CANARY DRIVE 20611 U.S.A. or Items 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married ρ 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced BLACK Year or Dates: "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed with ment of Health and Mental Hygiene. ant: If item 27 is marked other than ury or other traumatic avent, the M Maryland 21 12 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be JOSEPH MACK JONES FLORENCE BRADFORD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9503 CANARY DRIVE CAROLYN BARNES-DAUGHTER BEL ALTON, MD. 20611 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or ST.PETERS CEMETERY 1-6-04 WALDORF, MARYLAND 21. Signature of Funeral Service Licensee MOQ479 once RAYMOND FUNÉRAL SERVICE, P.A. LA PLATA, MARYLAND 20646 uch oce-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) **Physician** W22 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit the attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Dav 5 Other (specify) Yes 2 9 Unknown 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 20 No 2 🗆 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Hospital: 1 patient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Naturat 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident the 6 Could not be determined 3 ☐ Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D-46046 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMIR A. MIRZA ALIKHANI MD 118 LAGRANGE AVENUE LA PLATA MD 20646 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2004 Registrar

			For State Registrar	State of Ma	aryland /		artment <i>tificate</i>			d Mental H	ygier Reg. N	En W) [,	00829
	D		1. Decedent's Name (First, Middle, La	ist)						2. Date of I		ay Y	ear	3. Time of Death
	Physicia /Medic		Jung	Sun	1			На	m.	Janu		6, 200		7:47 Р м
	Examin		4a. Facility Name (If not institution, gir						ation of De	eath	4	c. County of	Death	
			304 Careybrook 1				Ft. Wa		gton Under 24 H	ire o n	N'-45	Prince	Geo	orge's
ı	Funeral Director		213-94-3385		9 (In yrs. last l 78	Yrs.			lours M		7192	5	Coun	korea
	and *		Usual Residence of Decedent 10a, State 10b, County		10c. City, To	wn or Lo	cation						10	Od. Inside City Limits
	Maryl f sho	or	Maryland Prince	George's	Fı	t. Wa	ashing	ton						1 ☐ Yes 2. KNo
	289 1000	Director	10e. Street and Number				10f. Zip C				10g. (Citizen of Wha	at Coun	try?
	3a ou	0	304 Careybrook L	ane				20744	1.			USA		
	death ms 2	Funeral	11. Marital Status	12. Was Decedent 8	Ever in U.S.	13.	Was Deceder	nt of Hispa	nic Origin?	(Specify Yes or I	No-	14. Race -		
21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, it is Medical Existential the notified at	ξ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes ② ↑ If Yes, Give Year or Dates:	10		r res, specily I⊡ Yes 2∛		pecify:	ierto Rican, etc.)		Black, Specify:		sian
ŏ	72 ho	Completed	15. Decedent's E (Specify only highest gi	ducation	16	Sa. Deced	ient's Usual kind of work	Occupation	na most of v	working	16b.	Kind of Busin	ess/Inc	lustry
2	thin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5	+)	life.	DO NOT use	retired)	ig most or v	HOIKING		T II		
7	ed wi	Cou		2		П(omemak				1	In Ho	ome	
Maryland	uld be filt fental H rked oth	To Be	17. Father's Name (First, Middle, Las Kun Lee)				18.		Name <i>(First, Midd</i> IKnown		on Sumame) Sung		
ary	and N		19a. Informant's Name/Relationship	(Туре, Print)	1					Rural Route Nun				·
Σ.	and and and and and and and and and and		Brian Ham / Son						en Dr	. Vienna				
ore	M iter		20a. Method of Disposition 1√2 Burial 2 ☐ Cremation 3 [Removal from State	ceme	tery, crer	sition (Name natory or oth	er place)		Date	20c.	Location - Cit	y or To	wn, State
Baltimore,	: Pag tment tant: jury		' 4 ☐ Donation 5 ☐ Other (Spec	(y)	Fairf	ax N	1em'l.	Park	01/	10/2004	Fai	rfax,	Vir	ginia
Ba	permit. Pages 1 Department of H Important: If ite any injury or ot once.		21. Signatur Funeral Service Lice	Sp.		6	160 Ox	on H	George ill R	e P. Kal oad Oxon	as F Hil	uneral I, Mar	y Ho	me P ₂ 0745
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	one cause on each lir	the death. D	o not ent	er the mode	of dying, s	uch as card	diac or respiratory	arr <i>e</i> st,			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a Cer	ebrov	ase	ular	A	ceide	em- (5+2	oke)		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as										
		Je.	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as	a consequenc	e of.								
\	d Insit	min	cause. Enter Underlying Cause (Disease or injury			,								
3	execu in and ial-tra	Еха	that initiated events resulting in death) Last	Due to (or as	a consequenc	e of):								
8760,	icate be executed physician and s the burial-transit	dical Examiner	•	d	· · · · · · · · · ·	· · · · · · · · · · · · · · · · · · ·	· · · · · · · · · · · · · · · · · · ·							
9	ertific Jing p	0	IF FEMALE:	23c. If yes, outcome	of progpancy									
Bo	attenc for us	lan	23b. Was decedent pregnant in the past 12 months?	1□Live birth	2 Fetal dea		Ectopic pr <i>e</i> g					23d. Date o Month		ry Day Y <i>e</i> ar
Records, P.O. Box	Physician: The law requires that the death certif this certificate has been signed by the attending ral director, page 2 should be detached for use a	Physiclan/M	1 ☐ Yes 2 ☒ ☒ o 9 ☐ Unknown	9□ Unknown	time or double	3	201101 (3000	,						
0	s that ned b s deta	by Pr	Part II. Other significant conditions	contributing to death b	ut not resulting	g in the u	nderlying cau	se given ir	Part I.	23e. Di	d tobacco	use contribu	ite to th	e cause of death?
ğ	w require been sig should b									_ 10] Yes	2 □ No 3[Proba	ably 4 Unknown
ဝွ	aw re as bec 2 sho	Completed								24a. W	as an topsy			osy findings available inpletion of cause of
m m	The late high	E O									rform <u>e</u> d?	dea	th?	2 No
/ita	cian: ertific sctor,	Be (25. Was case referred to medical examiner?						. Place of D	Death (Check onl	(one)			
<u></u>	hysion this co	၉	1 ☐ Yes ZXZMNo	Hospital: 1 Inpatie		_			4 🗌 Nursing	g Home 5√Re			Specify)
ono	Attending For death. ector: After by the funera	atlon;	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injur (Month, Day	Year) 28b	n. Time of Injury	M 280	: Injury at Work? 1 ☐ Yes	2 🗆 No	28d. Describ	e now in	ury occurred		
Division of Vital	5 5 th 6	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place of Injubuilding, etc	ury - At home, c. (Specify)	farm, str	eet, factory,	office			(Street own, Sta		or Rurai	Route Number,
_	To the Hospital within 24 hours a To the Funeral Completely filled	edical C		hysician: To the best of miner: On the basis of										
	the Phin 24 the F	Medi	one) 29b. Signature and title of certifier	and manner sta	ited.			License nu				ate signed (A		
	To To		255. Signature and title of certifier	1 1 "	٨	1 1				480		-		2004
			30. Name and address of person who	completed cause of d	eath (Item 23:	a) (Type		10 1	1 (7		-
			Muhammad Ali MI					Alexa	andris	a. Virai	ni o	2230	2	
	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature					*************************	rid		-	
	Registi	ar	AHIA TO S	12 34	as B	RIS	and of							

		1 - For State Registrar	of Maryland / Do		ent of H		nd Menta	l Hygie	- ZUU	4 00830
	-31	Decedent's Name (First, Middle, Last)					2. Date Mor	of Death	Day Yes	3. Time of Death
Physici /Medi		JOSEPH WALLACE J	ENKINS				JA	N. 4,	2004	6:00 A ^M
Examir		4a. Facility Name (If not institution, give street and		4b. C	city, Town, or				4c. County of D	
		GENESIS LA PLATA C 5. Social Security Number 6. Sex	ENTER 7. Age (In yrs. last birth	day) If Ur	nder 1 Year	A PLA		of Birth		Birthplace (State or Foreign
Funeral Director		217-36-6504		Mont			Min. OCT	of Birth onth, Day, Ye 16, 1	913 M	RYLAND
D		Usual Residence of Decedent								101 (-11-0)-11-11-
arylan show	-	10a. State 10b. County MARYLAND CHARLES	10c. City, Town	or Location	T.A	PLATA				10d. fnside City Limits
be Ma Sa-1 s	Directo			104	Zip Code			100	Citizen of Whet	
with t	ā	1 MAGNOLIA DRIVE		101.		0646			U.S.2	
death ms 23	Funeral	11 Marital Status 12. Was D	ecedent Ever in U.S.	13. Was D	ecedent of Hi	spanic Origin	n? (Specify Ye Puerto Rican, o	s or No-		merican Indian,
or Ite	돌	Armed	Forces?		specify Cubai s 2 ∑ No	n, mexican, r Specify:	ruento Alcan, i	a(C.)	Specify:	/hite, etc. WHITE
ours lener;	d by	3 Widowed 4 Divorced Year of	r Dates: WWII					1.00		
natural part	Completed	15. Decedent's Education (Specify only highest grade complete	ed) (Give kind o	Jsual Occupa I work done d T use retired,	luring most o	of working	160	o. Kind of Busine	ss/industry
within them.	dmo	Elementary/Secondary (0-12) Colfeg	e (1-4or 5+)	FA	RMER				FARN	MING
be filed within 72 hours after death with the Maryland hall Hygiene. Id bygiene. Id other than "naturel", or Items 23e or 28e-1 show syent, I'm Medicul Exprines minaturel as	a)	17. Father's Name (First, Middle, Last)					s Name (First,		den Sumame)	
should be a should	To B	JOSEPH HARRY JEN					LSIE L			
and and		19a. Informant's Name/Relationship (Type, Print) ELAINE BURDETTE-DAU			ress <i>(Str</i> eet a RAIN				ity or Town, Stat	o, Zip Code) D• 20695
St and 2: of Health are item 27 is		20a. Method of Disposition	20b. Place of I	Disposition	Name of	- 1	Date	-	Location - City	
Daltillor permit. Pages 1 Department of b Important: If its any injury or ot once.		1 N Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	om State RESURREC		or other place CEME		1-7-0	4 CI	LINTON	, MARYLAND
Dallillo permit. Pages Department of Important: If it sny injury or o		21. Signature of Funeral Service Licensee	M00479 /	722 Nam	e and Addres	s of Facility			א ת שור	
Departing once.		Muchael O.	Smy	LA	PLAT	A, MAE	RYLAND	2064	CE,P.A. 46	
		23a. Part1. Enter the disease, or complications the shock, or heart faifure. List only one cause	at caused the death. Do no	ot enter the	mode of dying	g, such as ca	ardiac or respir	atory arrest,		Approximate Interval Between Offset and Death
Physician		fmmediate Cause (Final disease or condition	NEUMO	NI	A					I LIK
/Medical Examiner		resulting in death) Due	to (or as a consequence o	f):						
	i i	Sequentially list conditions, if any, leading to immediate Due	to (or as a consequence o	f):						
uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c								
D, exect an and rial-tra		resulting in death) Last Due	to (or as a consequence o	f):					-	
wrequires that the death certificate be executed been signed by the attending physician and should be detached for use as the burist-transit	Ilcal	d								
X O	Physiclan/Med	fF FEMALE: 23c ff yes	outcome of pregnancy						23d. Date of	dolinon
BOX eath cer attendin for use	clan	in the past 12 months?	ve birth 2 Fetal death		ic pregnancy r (specify)				Month	Day Year
the d	ysic		nknown							
Ords, F.O. requires that the neen signed by th hould be detache	by Pt	Part fl. Other significant conditions contributing	o death but not resulting in	the underly	ng cause give	en in Part I.	23	e. Did tobac		e to the cause of death?
w requires been sign should be	ted	ALZEPILMER	DIJUI	70				1 🗌 Yes	2 No 3	Probably 4 Unknown
law re law re law re las be	ompleted	Stigure 2	gisordo	((24	a. Was an autopsy	24b. Were prior	autopsy findings available to completion of cause of
The law cate has I	Con						10	Performed Yes 2	d? deat	Yes 2□ No
Or VIKAL P Physician: Th this certificate rai director, pag	Be	25. Was case referred to medical examiner?			Othi		of Death (Chec		e 6 Other (
Phys r this arai di	To To		Inpatient 2 ER/Out ate of fnjury fonth, Day Year) 28b. T	me of	28c. Injun Worl				injury occurred	specity)
nding ath. r: Afte	atloi	1 DNatural 5 Pending (7 2 Accident investigation	wonth, Day Year)	jury M		Yes 2 □ N	0			
DIVISION or Attending after death. Director: After in by the function	Certification:	3 Suicide 6 Could not be determined 28e. P	lace of Injury - At home, far uilding, etc. (Specify)	m, street, fa	ctory, office			cation (Stree y or Town, S		r Rural Route Number,
Urs aft										
DIVISION OF To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	Medical	29a. Certifier 1 Certifying Physicien: To (Check only 2 Medical Examiner: On the one)								
ro the rother comple	Me	29b. Signature and title of certifier	Y		29c. License			29d.	Date signed (M	Ionth, Day, Year)
ن اخر		1 Gall	ATTENDIN	9	D	44	436	J	AN C	15 2004
51		30. Name and address of person who completed	cause of death (flown 23a) (Type, Print)	In a	2	1611	1	LAIN	15 2007 0RFM) 20602
/		ASHVINKUMAK	2. Registrar's Signature	-7_	1021	AULI	VICTION	V (1	WALD	14-M 2002
Si Regis	tate trar	31. Date filed (Month, Day, Year) 3	A Programation	18	Somet's	7 15				

DHMH 17 Rev 1/2001

			1 - For State Registrar		laryland / Do	epartmer Certificat			nd M		giene 2 ()	04	00	831
	Physic	an	Decedent's Name (First, Middle	•						2. Date of Dea	ath Day	Year	3. Time o	of Death
	/Medi	cal	James	Edward	Marsh					JANUARY		2004	1330) P ^M
	Examir	ner	4a. Facility Name (If not institution)			Location of	Death		4c. County			
	Funeral		MEMORIAL HOSPIT 5. Social Security Number		ge (In yrs. last birth		ERLA r 1 Year	ND If Under 24	4 Hrs.	8 Date of Birt	ALLEG		ace (State	or Foreign
	Director		228-40-3669	1 🔀 M 2 🗆 F	67 Y	Months		Hours	Min.	8. Date of Birt (Month, Dat Jul 2	D. 1936	Coun	ZA	or roreign
	Pu ,		Usual Residence of Decedent		T						,			
	e Marylau ta-f show Ililied al	ctor	MD 10b. County Alle	gany	10c. City, Town	or Location dtown						11	od. Inside C 1 ☐ Yes	ity Limits
	th with th	Funeral Director	17515 Old Brace	ldock Trail		10f. Zi	Code	21555			10g. Citizen of V	What Coun	try?	
9600	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Importent: If Item 27 is marked other than "natural", or items 23e or 28e-1 show stripping or other treumatic event, the Madical Examinar must be notified at ance.	by	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorced	12. Was Deceden Armed Forces ad 1 XYes 2 If Yes, Give Year or Dates:	?	13. Was Dece If Yes, spe 1 \(\sum \) Yes	V	spanic Origin, Mexican, Specify:	n? (Spe Puerto l	cify Yes or No- Rican, etc.)		e - America ck, White, e	etc.	
<u>7</u>	nati	ete	15. Decedent (Specify only highes	s Education grade completed)	16a. D	ecedent's Usu Give kind of wo fe. DO NOT u	al Occupa	ation fu <i>ring</i> mo <i>st</i> o	of workir	ng	16b. Kind of Bu	siness/ind	ustry	
12	within ene. than be Mas	Completed	Elementary/Secondary (0-12)	College (1-4or		v Office)		1	II S No			
d 2	e filed vall Hygie other t	ပိ	17. Father's Name (First, Middle, L	ast)	1 011	y Office	.1	18. Mother's	s Name		U.S. Na Maiden Sumam			
Maryland 21215-0036	2 should be and Mental is marked or reumatic eve	To Be	unknown			-		unkr	าดพเ	n				
	and 2 st ealth and m 27 is n		19a. Informant's Name/Relationsh Jeweral Marsha	II wife				addock	or Aurai (Tra	ail Oldto	r, City or Town, WN	State, Zip	/ID 21	1555
Baltimore,	Pages 1 nent of H ant: If ite ary or otl		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		20b. Place of D cemetery, Rocky G	crematory or c	ther place	emetery		ate 1/9/2004	Flintsto	-		MD
Balt	permit. Pag Department Importent: any injury o		21. Signature of Funeral Service L	icepsee Aery	elli	22. Nam Sar	afpen 8 Viro	i Funera	al Ho	me, PA	land, MD	21502		
			23a. Part1. Enler the disease, or o shock, or heart failure. List of	complications that cause	d the death. Do not	enter the mod	le of dying	, such as ca	ırdiac or	respiratory arr	est,		Approximat Interval Bet	е
vos.	Physician /Medical Examiner		tmmediate Cause (Final disease or condition resulting in death)	- Brady	arrhythr								Onset and	Death
8760,	icate be executed physician and s the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	a consequence of)									
P.O. Box 68	The law requires that the death certificate be executed ten has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death	3 ☐ Ectopic pr 5 ☐ Other (sp					23d. Date Mon	of deliver		/ear
rds, F	quires tha n signed l uid be det	by	Part II. Other significant condition	s contributing to death t	out not resulting in th	e underlying c	ause give	n in Part I.		1	pacco use contri es 2 □ No		cause of d	
Reco	rstctan: The law requir s certificate has been si lirector, page 2 should I	Completed							_	24a. Was a autops perform	у ! р	/ere autop: rior to com eath?	sy findings a	available ause of
		0	25. Was case referred to medical					00 Plans of		1 ☐ Yes 2	No 1		IX No	
Division of Vital Records,	£ 12 0	atlon; To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigs	Hospital: 1 Inpatie 28a. Date of Inju (Month, Da			A Other	. 4 🗆 Nursi	ng Hom		nce 6 Othe			
DIVIS	ef or Attences after death	Certification;	3 Suicide 6 Could no 4 Homicide determin	ed 286. Place of in	ury - At home, farm, c. (Specify)	street, factory	, office		28	3f. Location (Sti City or Town	reet and Numbe , State)	r or Aural	Route Numi	ber,
	To the Hospitel or within 24 hours after To the Funeral Director Completely filled in D	edical	29a. Certifier (Check only one) 1 Certifying 2 Medical E	Physician: To the best caminer: On the basis o and manner st	f examination and/o	eath occurred a r investigation,	at the time in my opi	e, date and p nion, death o	place, an	nd due to the ca	use(s) and man ite and place, a	ner as stai	ed. ne cause(s)	
	To the within 2 To the complet	ž	29b. Signature and title of certifier			29c	License	number		29	d. Date signed	(Month, Da	y, Year)	
				-01		D2	3371			V	anuary "	9,200	4	
	2		30. Name and address of person w			oe, Print)					1			
			QAMAR ZAMAN, MD			BERLAND	,MD	21502						
	Stat Registra		31. Date filed (Month, Day, Year) JAN	1 5 2004	ar's Signature	1. Los	whi.s	7 -						

		. For	i lease i	State of M		d / Dep	artmen	t of He	alth ar						*
		1 - For State Registrar				Ce	rtificat	e of D	eath	- 7		Reg. No	. 200	3 UI	1832
	sician edical	1. Decedent's Name (F	irst, Middle, Last)	HER	286	RG				2.	Date of De Month	Day	Yeer Xe Zeo	3. Time	of Death
	miner	4a. Fecility Name (If no	11 111	/ /	na /	-10	4b. City,	Town, or L	ocation of	Death	1	/ 4c.	County of Dea	th	
15		University	of Illai		redu	ay ap	If Under	Level	If Under 24	1 Hrs D	Date of Bir	db	l o Bir	thalana (Stat	o or Foreign
Fune Direct		5. Social Security Number 214 32	7325 10	M 2 F 7. A	85°	last birthday, Yrs.	Months	Days		Min.	Month, De	y, Yeer)		ountry)	e or Foreign nd
and		Usual Residence of De	cedent b. County		10c. City	, Town or L	ocation							10d. Inside	City Limits
Maryli f sho	ō	MD	Kent		Ch	este	rt our	,						1 32 1 Y	es 2 No
r 28e	<u>1</u>	10e. Street and Number				es ce.	10f. Zip					10g. Cit	izen of What C	ountry?	
th with	Funeral Director	402 Morg	nec Rd.	Apt. 6	5-B		2	1620				Ţ	J.S.A.		
r dea	Je L	11. Marital Status	12	2. Was Decedent Armed Forces	?	S. 13.	Was Dece	dent of Hisp cify Cuban,	oanic Origi Mexican,	n? (Specify Puerto Rica	Yes or No an, etc.)	0~	14. Race - Ame Black, Whi		,
ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If the 21st marked other than "natural", or items 23s or 28s-f show other traumatic event. If we deat same arminate countries and the control of the countries of the countries arminate countries.	by Ft	3 ☐ Widowed 4 ☐		1 ☐ Yes 2 🔀 If Yes, Give Year or Dates:	No		1 🗆 Yes	2 X No	Specify:				Specify: V	Thite	
5-0 72 ho 72 ho	Completed	(Specify	. Decedent's Educationly highest grade	ation completed)		(Give	dent's Usua kind of wo	rk done du	on ring most o	of working			ind of Business	Industry/	
121 within	ign ign	Elementary/Seconda	ry (0-12)	College (1-4or	5+)		<i>во мот и</i> .e In	,	tor			1	othing nufact	urar	
of filed within at Hygiene.	ပိ		st, Middle, Last)			D111				s Name (F	irst, Middle	1	Sumame)	urer	-
ld be ked c	To Be		Fields						Clar	a Em	orv	,			
Maryland d 2 should be file th and Mental Hy 17 is marked oth		19a. Informant's Name		e, Print)		19b. Maili	ing Address	(Street an				er, City o	or Town, State,	Zip Code)	
and 2 and 2 m 27 i		Alex W. I		ı III (son)	-	-		Ave.		-		, MD.		
Baltimore, permit. Pages 1 ar Department of Heal Importent: If Item Pays Indian Pays India		20a. Method of Dispos	tion remation 3 □Re	moval from State	, a	face of Displemetery, cre	matory or o	other place)	i	Date	- 4		ocation - City or		
Baltimo Dermit. Page Department of mportent: If my injury or		'4 □Donation 5			Ke	nt Ci				/8/0			rna, I		
Balting permit. Pa Department importent	ouce	21. Signature of Funer)0		м005	10	118 V	Vest_	Cros	s St	. Ga	len	tepher	L So 216	chaecl 35
चिह्न "भू		23a. Part1. Enter the shock, or hear fa Immediate Cause (Fin		ations that cause cause on each	/		ter the mod	de of dying,	such as ca	ardiac or re	spiratory a	rrest,		Approxin Interval E Onset ar	Between
Pnysici /Medic	_	disease or condition resulting in death)	a.	Due to (r a:	na comega		erf	VICO /1	en					-	
Examin	er			Mal	liast	nit	Sel	reis						24	70
OP 5	ner	Sequential y list condit if any, leading to imme cause. Enter Underlyi Cause (Disease or inju-	ions, idiate	Due to (or a.	à consequ	uence of):									
ecute and	Examiner	Cause (Disease or inju that initiated events resulting in death) Las	C.	Due to (or as	2 000000	unnee of):									
3760 X ate be executed hysician and he burial-transit	cai E			Due to (or as	a consequ	derice or).									
687 ifficate g physical	g		d.												
. Box 68 death certificate eattending phy of for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pr	egnant 23	c. If yes, outcome									23d. Date of de	ivery	
. 0 0 9	icia	in the past 12 mg	nths?	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown			□Ectopic pi □ Other (sp						Month	Day	Year
- ± 50	Phys	9 Unknowh			1	and the same			1. D. 41		20- Did				danth?
	۵	Part II, Other significa	ni conditions con	ribiting to death	out not rest	uiting in the t	inderlying o	ause given	in Part I.				use contribute to	obably 4	
Records he law requires a has been sign	Completed		L	an										an a series	-
Rec The law ite has b	ign	- jugge	Tenyo	07						-	24a. Was auto perfo	psy ormed?	death?	completion o	of cause of
_ F	ပိ	25. Was case referred	to medical						Of Place o	of Death (C	1 Yes	2 No	1 \ Yes	No No	
	, 0	examiner?		spital: 1 Ninpat	ent 2	ER/Outpatie	nt 3 D	Other					6 □Other (Spe	cify)	
of Physical Clinical	ı.	27. Manner of Jeath	5 ☐ Pending	28a. Date of Inj	ury	28b. Time o	of 2	28c. Injury a Work?	it				ry occurred		
Vision Attending r death. ector: After	satic	1 Natural 2 Accident	investigation				М	1 🗆 Ye	s 2 🗆 No						
Division or Attending after death. Director: After	Certification:	3 ☐ Suicide 4 ☐ Homicide	determined	28e. Place of Ir building, e	ijury - At ho tc. (Specif)		reet, factor	y, office		28f.	City or To		nd Number or R e)	urai Route N	umber,
Division or To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Attert Complately filled in by the funeral	edical C	29a. Certifier 1((Check only 2)	Cartifying Physi Madical Examin	cian: To the bes er: On the basis and manner s	of examina	wledge, dea tion and/or in	th occurred	at the time, i, in my opir	, date and nion, death	place, and occurred a					e(s)
To the within 2 To the complet	Z V	29b. Signature and title	of certifier				29	c. License r	number			29d. Da	te signed (Moni	h, Day, Year)
PSPO		Kriner	AKE.	Xann	, n	2		D 5	3898			tan	nange	16 2	004
17		30. Name a address	of pers who co	pleted cause of	death (Item	1 23a) (Type		./-		41.4	Λ	2	te signed (Moni		
		UMAIS	22.	S. Cillo	ne	4	130	Mhr	NR	m	<i>y</i> =	012	1		
Reg	State jistrar	31. Date filed (Month,	Day, Year) DN 1-5-20	32. Regist	rar's Signa	iture	brack	الر							

DHMH 17 Rev 1/2001

ORIGINAL

Martha G. Poole 04-0131

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	AKG		1 - For Unpend Item #23	State of Maryland / a&27 per me G828 2/5	Departi /04 tae	ment of F	leaith and Death	Mental Hy	giene Reg. No	2004	00833
	Physici	an	1. Decedent's Name (First, Middle, Las	t)				2. Date of De			3. Time of Death
	/Medic	cal	Martha G. Pool 4a. Fecility Name (If not institution, give		4b	. Citv. Town. o	r Location of Dea	Janua:		2004 County of Death	1:46 PM
	Examin Funeral Director	ier	Anne Arundel Me 5. Social Security Number 6. So	dical Center	Ai pirthday) If	nnapoli Under 1 Year onths Days	S	8. Date of Bi	Aı Th	one Aruno	lace (State or Foreign
	and w _		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Location	on				1	0d. Inside City Limits
	Maryl.	tor	Maryland Anne A	rundel Mille	ersvi	lle					1 1 Yes 2 □ No
	h with the 23a or 28a	Funeral Director	10e. Street and Number 291 Charles Ha	11 Dr.	1	Of. Zip Code 21108				izen of What Coun	ntry?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental hygiene. Important: If item 27 te marked other then "natural", or items 23e or 28e-f show eny injury or other traumatic event, I a Medical Evarializer must be inclified at ODGE.	þ	11. Marital Status 1 Never Married 2 Married CWidowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates:		Decedent of H s, specify Cub Yes 2X No	lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No nto Rican, etc.))-	14. Race - Americ Black, White, Specify: B1:	etc.
21215-0036	ithio 72 ho ne. nen "natur Medical	Completed	15. Decedent's Ed (Specify only highest grant Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give kind life. DO f		during most of wo d)	orking		ind of Business/Ind	
	12 should be filed within hand Menial Hygiene. 7 le marked other then "Iraumatic event, in a Men	To Be Col	12th 17. Father's Name (First, Middle, Last) Harrison Johns	2yrs on	Mus	sician		me (First, Middle Hall		ech Orga Sumame)	anist
Maryland	ind 2 shou alth and M 127 le mai		19a. Informant's Name/Relationship (Chery1 Poole (Da		_				-	n Town, State, Zip	
Baltimore,	Pages 1 and of Hernard It is the mint: If item		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State Johnst		n (Name of ny or other plac	1-12	Date 2 - 0 4		erbury,	
Balti	permit. Departm Importa eny inju		21. Signature of Funeral Service Licentary & Service					s Mortu		, P.A.	1
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition	olications that caused the death. Do one cause on each line. a. Hypertensive Ather	o not enter th	e mode of dyir	ng, such as cardia	c or respiratory a			Approximate Interval Between Onset and Death
4	/Medical Examiner		resulting in death)	Due to (or as a consequence							
,00	death certificate be executed e attending physician and of for use as the burial-transit	Examiner	Sequential Vilst conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c							
68760,	ificate be g physic as the bu	edicai		d							
O. Box	0 0	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal dea: 4□Pregnant at time of death 9□Unknown		opic pregnancy ner (specify)	/			23d. Date of delive Month	Day Year
4	w requires that the been signed by the should be detache	b	Part II. Other significant conditions of	ontributing to death but not resulting	in the under	lying cause giv	en in Part I.		obacco u Yes 21	se contribute to th	/
al Records,	The la ate has page 2	Completed						24a. Was auto perfo 1 Yes		prior to con death?	psy findings available apletion of cause of
Vital	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ★ Yes 2 □ No	Hospital:	Outpatient 3	B DOA Oth	or:	ath (Check only of Best		6 □Other (Specify	()
ion of	E fe e		27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	. Time of Injury	28c. Injur Wor		28d. Describe			,
Division	s after des	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street,	factory, office		28f. Location (City or To	Street an wn, State	d Number or Rura.)	l Route Number,
	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical (29a. Certifier 1☐ Certifying Ph (Check only one) 2☑ Medical Exam	ysician: To the best of my knowled niner: On the basis of examination a and manner stated.	ge, death oca and/or investi	curred at the tiring ation, in my d	me, date and place pinion, death occ	e, and due to the urred at the time,	cause(s) date and	and manner as st. I place, and due to	ated. the cause(s)
\	To the To the To the Complex c	Σ	29b. Signature and title of certifier	-0000		29c. Licens			29d. Dat	e signed (Month, L	Day, Year)
,			30 Name and address of person who	completed cause of death (Item 23a) (Type, Prin	O.C.M	I.E.	ز	Janua	ary 6, 20	004
			PATRICIA AGO	NICA-POLLAK	LWD		enn Stree	et, Balt	imore	e, Maryla	and 21201
d	Sta Registi		31. Date filed (Month, Day, Year) JAN 1 2	32. Refistrar's Signature	1					-	

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Marylar		artment of H		-	giene Reg. No.	004	00830
	Physici	an	1. Decedent's Name (First, Middle, Las					2. Date of De Month	Day	Year	3. Time of Death
	/Media	al	Ramona Elaine 4a. Facility Name (If not institution, give			4b. City, Town, or	r Location of Deat	JANUA		2004 Inty of Death	10:25 M
	Examir	er	Saint Joseph		nter	10. 04,7, 104,7, 04	Tow		10.000	_	imore
	Funeral Director		5. Social Security Number 216-20-4444 6. So	9x □ M 2X F 7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		7, 192	9. Birthpl Count Mary	ace (State or Foreign ry) yland
	and		Usual Residence of Decedent 10a. State 10b. County	. 10c. Ci	ty, Town or Lo	ocation		-		10	d. Inside City Limits
	Maryl II eho	tor	MD Carrol	1 На	ampste	ead					1 ☐ Yes 2 No
	or 288	Olrec	10e. Street and Number			10f. Zip Code				of What Count	ry?
	death with the Maryland rms 23s or 28s-f show rman be notified at	ral	3840 Normandy		6 113	2107		Sacatu Van ar Na	U.S	· A ·	an Indian
36	ges 1 and 2 should be filed within 72 hours after death with the Marylan at of Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23s or 28s-f ehow or other traumatic event. Its Wedeal Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	ŀ	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	Specify:	to Rican, etc.)	E	Black, White, e	
2-0	72 hou	eted	15. Decedent's Ed (Specify only highest gra	lucation de completed)	(Give	dent's Usual Occup- kind of work done of	durina most of wo	rkina	16b. Kind o	Business/Ind	ustry
21215-0036	within ene. then	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	1)	•	Law E	nforce	ment
	filed v Hygie other t	e Co	12 17. Father's Name (First, Middle, Last)	A Marian	Keyl	ounch Op		me (First, Middle			
lan	should be nd Mental marked c	To Be	Harry E. Duva	11			Ernie	e Wider	man		
Maryland	and 2 shores and 8 salth and 6 nr 27 is ma		19a. Informant's Name/Relationship (7) William H. Zellma		1	ng Address (Street a					Code) 131
Baltimore,	ages 1 are ant of Hea it: If item y or othe		20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 📉 4 □ Donation 5 □ Other (Specify	Bernoval from State	Place of Dispo cemetery, crei	osition (Name of matory or other place dom Cemete	a) Jan	Date 12	20c. Locatio	on - City or Tov	
Baltir	permit. Pages 1 an Department of Heali Important: If item 2 eny injury or other once.		21. Signature of Funer II Salvige Licen	- control in the cont	22	2. Name and Address	ss of Facility J.	J. Hart	enstei	n Mortu	ary, Inc.
			23a. Part1. Erver the disease, or comp spock, of heart failure. List only	olications that caused the deat	h. Do not ent	er the mode of dyin	g, such as cardia	c or respiratory a	rrest,		Approximate Interval Between
w i	Physician		Immidiate Cause (Final dis se or condition	a CONGESTIV	E HER	RT FAIL	URE				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq CORONARY		V DICEA	ec				
	10000000000000000000000000000000000000	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conseq		IT I/IOEM					
)	cate be executed physicien and the burial-transit	Examiner	that initiated events	c CHRONIC C		CTIVE P	ULMONAE	Y DISE	ASE		
8760,	be exercien a	EX	resulting in death) Last	Due to (or as a conseq	uence of):						
687	ficate physics the	edica	-	d							
Вох	The law requires that the death certificate be executed tte has been signed by the attending physicien and oage 2 should be detached for use as the burial-transit	Physician/Medical	in the past 12 plonths?	23c. If yes, outcome of pregna 1☐Live birth 2☐Fete 4☐Pregnant at time of d 9☐Unknown	death 3	Ectopic pregnancy Other (specify)				Date of deliver Month [y Day Year
P.O.	hat the		9 Unknown Part II. Other significant conditions or		ulting in the u	nderlying cause give	an in Part I	23e. Did to	obacco use co	ontribute to the	cause of death?
of Vital Records,	w requires t been signe should be	ed by						10	1/		
ecc	e law re has be	Completed						24a. Was autop	osv	b. Were autops prior to com death?	sy findings available pletion of cause of
a F			25 Man ages retarred to medical				00 81 - 48		2 No		No.
<u> </u>	/sicial	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 M No	Hospital: 1 X Inpatient 2	ER/Outpatier	t 3 DOA Othe	ar:	ath <i>(Check only c</i> fome 5☐ Resid		Other (Specify)	
ion of	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific: completely filled in by the funeral director.		27. Manner of Dath 1 Natural 5 Pending 2 Accident investigation	28a. Dite of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	1.4	28d. Describe			
Division	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str	eet, factory, office		28f. Location (S City or Tox		mber or Rural	Route Number,
	Ne Hospit	edical (29a. Certifier (Check only one) 1 Certifying Ph	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wiedge, death	n occurred at the tim vestigation, in my op	ne, date and place pinion, death occu	and due to the irred at the time,	cause(s) and date and plac	manner as sta e, and due to t	ted. he cause(s)
	To the I within 2 To the I complet	Ň	29b. Signature and title of certifier	00 - 11 -		29c. License	number		29d. Date sig	ned (Month, D.	ay, Year)
1	1		goninin	The the	n.O		041410	7	onwarn	097	2014
	8		30. Name and address of person who o	completed cause of death (Item							
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	7621 iture	OSLER D	RIVE TO	WSON.	MUBAF	AND 21	274
	Registr	1.00	I NAL.	4 2004	3.0	and the same	No. V.				

ORIGINAL

	For State of Ivial year of Ivial year of Ivial year	ertificate of Death	Reg. No.	3. Time of Death
Physician /Medical		RENNER, SR.	January 6 200	,
Examiner	4a. Facility Name (If not institution, give street and number) Carroll Hospital Center	4b. City, Town, or Location of Death Westminster	4c. County of De Carro	
Funeral Director	5. Social Security Number 217–50–5443 Usual Residence of Decedent 6. Sex 1 N 2 F 7. Age (In yrs. last birthday) 54 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Dey, Yeer) April 27,1949 Mg	irthplace (State or Foreign Country) aryland
Aaryland rehow	10a. State 10b. County 10c. City, Town or L Maryland Frederick Keyman			10d. Inside City Limits 1 ☐ Yes 21€ No
RENNE death with the Marylar ma 23e or 28a-1 show Evant by mulified at neral Director	10e. Street and Number 12337 Warner Road	10f. Zip Code 21757	10g. Citizen of What C	
P 2 2 2	11. Marital Status 1 Never Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 12. Was Decedent Ever in U.S. Armed Forces? 14. Yes 2 No If Yes, Give 1970–73	Was Decedent of Hispanic Origin? (Spr If Yas, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.) 14. Race - An Black, Wt Specify: W	
nd 21215-0036 nd 21215-0036 se filed within 72 hours aft lat Hygiene. d other than 'netural', or swart, fire M. dical Exerted Be Completed by F	15. Decedent's Education (Specify only highest grade completed) (Giv life. Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of worki DO NOT use retired)	16b. Kind of Busines	•
laryland 2121 2 should be filed withir and Mental Hygiene is marked other than aumatic event, the M. To Be Comp	11 17. Father's Name (First, Middle, Last)	Plumber 18. Mother's Name	(First, Middle, Meiden Surname)	& Heating
Maryland Maryland ad 2 should be file th and Mental Hy 27 is marked oth treumatic evant		ing Address (Street and Number or Rura		Zip Code)
ore, M is 1 and 2 of Health item 27 is other tre	Manager and the second	amatory or other place)	Date 20c. Location - City of	
Baltimore, Mar Bartimore, Mar permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is n important: If Item 27 is n any injury or other treun	4 Donation 5 Dotter (Specify)	2 Name and Address of Facility	0,2004 Rocky Ride	ge, MD
Bal Bal Bal Bal Bal Bal Bal Bal Bal Bal	23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	36 E. Baltimore St	les Funeral Home ., Taneytown, MD	21787 Approximate
Physician /Medical	Immediate Cause (Final disease or condition resulting in death)	lynged concer		Interval Between Onset and Death
Examiner	Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
executed in and in-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):			
Box 68760, eath certificate be executed attending physician and for use as the burial-transit clan/Medical Examir	d			
I Records, P.O. Box (The law requires that the death certified has been signed by the attending page 2 should be detached for use a completed by Physiclan/Me		□Ectopic pregnancy □ Other (specify)	23d. Date of de Month	elivery Day Year
ecords, P. law requires that the as been signed by a should be detailed by the appleted by Ph.	Part II. Dther significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute 1 Yes 2 No 3 F	_
Division of Vital Records, P.O. to Attanding Physician: The law requires that the drafter death. Director: After this certificate has been signed by the tinneral director, page 2 should be detached ertification: To Be Completed by Physician Division of the completed by Physician Division of the completed by Physician of the Completed by Physician of the Completed by Physician of the Completed by Physician of the Completed by Physician of the Completed			performed? death?	uutopsy findings available completion of cause of
of Vital hysician: his certifica il director.	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie		Check on one ne 5 ☐ Residence 6 ☐ Other (Sp.	
Division C trat or Attanding P is after death. al Director: After t led in by the funera Certification:	27. Manngrof Death 1. Natural 5 Pending (Month, Day Year) 2 Accident investigation 3 Suicide 6 Could not be	Work? M 1 Yes 2 No	28d. Describe how injury occurred	
Divisic To the Hospital or Attance within 24 hours after death To the Funeral Director: completely filled in by the Medical Certifical	4 Homicide determined building, etc. (Specify)		28f. Location (Street and Number or F City or Town, State)	
the Hospital thin 24 hours a the Funeral I mipletely filled	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, deal cal Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, a expecting tion, in my opinion, death occurred	and due to the cause(s) and manner a ed at the time, date and place, and du	s stated. e to the cause(s)
To the within 2 To the comple	29b. Signatore and title of certifier	29c. License number	29d. Date signed (Mon	th, Day, Year)
5	30. Name and address of person who completed cause of death (Item 23a) (Type	Print) 200 Memorial	Avenue	
State	31. Date filed (Month, Day, Year) 32. Registrar's Signature	wi won recoster	~ X110/	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Ola	te or ivial	yland / D	-	ificate of				gierie Reg. No. 2 (004	00836
	Dhoristan	1. Decedent's Name (First,	Middle, Lest)							2. Dete of De	eth .	V	3. Time of Death
-	Physician /Medical	Eva Alv	verta Ru	ssell						Janua	Dey 8, 2	Yeer 204	12:40 PM
	Examiner	4e Fecility Neme (If not ins	-	,						cation of Death	4c. County	y of Deeth	
•			eredith						te H			timo	re
	Funeral J Director	5. Social Security Number 187-24-087		7. Age 7.	(In yrs. lest birth	7/	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da Dec • 7	, 1929	9. Birthpl Count Mar	lece (State or Foreign try) Cyland
	and w	Usuel Residence of Deceder 10a. State 10b. C		1	IOc. City, Town	or Loca	tion					10	0d. Inside City Limits
	Many	MD Ba	Ltimore		Whit	□ н	all						1 ☐ Yes 2 No
	rec	10e. Street end Number			***************************************		10f. Zip Code	-			10g. Citizen of	What Coun!	try?
	th with	2637 Me	eredith	Road			211	61			U.S.A		
Maryland 21215-0020	uld be filed within 72 hours after death with the Maryland Mental Hygiene. Inted other than "natural", or items 23a or 28e-f show afte event, the Medical Examinat natal be notified at To Be Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 [Ž 3 ☐ Widowed 4 ☐ Div	Married 1 ☐	s Decedent Ev led Forces? Yes 2∑ No es, Give ir or Dates:	er in U,S.		s Decedent of Fes, specify Cub. Yes 2 No			cify Yes or No- Rican, etc.)	14. Rad Bla Specif	ce - America ck, White, e fy: Wh	
S O	uld be filed within 72 hoi Mental Hygiene. Irked other than "natura atic event, the Medical is To Be Completed	15. Dec	edent's Education nighest grede compl	eted)	16a. D	eceden	t's Usual Occup	petion	t of workin	10	16b. Kind of B	usiness/Ind	ustry
2	ithin ne.	Elementary/Secondary (0		ege (1-4or 5+)			d of work done NOT use retire			'9			
2	Hygier that the Cor	8	dda Laatt		T	eac	her As				-	atio	n
and	SES Q	17. Father's Neme (First, Mi	dame, Lest) d E. Wri	ah+							Maiden Suman	ne)	
2	d Me	19a. Informant's Name/Rela		_	7 105 1	deilie -	Address (Ctores			va En	-		
Σ	id 2 s Ith an 17 is i	William G.	Russel'	" Husba I .Tr			Address (Street Mered.						
ō,	is 1 and 2 should if the alth and Men item 27 is marke other traumatic	20a. Method of Disposition		T	20h Place of D	ispositi	on (Name of		ια.,	Dete	20c. Location		
Baltimore,	permit. Pages Department of Important: If it any injury or once.	1 M Burial 2 ☐ Crema 4 ☐ Donetion 5 ☐ Oth	er (Specify)	from State	West Li Method				20	an. 13,	White		
g	Demi Depa Impo any ir	21. Sig three of Fineral S	Man Se	tens	toni	J.	J. Har Second	tens	tein	Morti	lary,	Inc.	7349
	Physician	23a. Part1. Enter the disease shock, or he m failure.	e, or complications List only one cause	that caused the on each line.	e death. Do no	enter t	he mode of dyin	ng, such as	cardiac or	respiratory and	est,		Approximate Interval Between Onset and Death
	/Medical	Immediate Ceuse (Final		. 4 11	, ,		i						
	Examiner	disease or condition resulting in death)	e	14/ti	e to (or as e co	12/0	ma	-					7 420.5
	D =				10 (01 23 6 00	isaquai	ilcə or).					1	
	death certificate be executed e attending physician and od for use as the burial-transit ilclan/Medical Examiner	Sequentially list conditions,	₽ b.—	บิง	e to (o, as a cor	seque	тсе отј.					1	
Š	oe execution a surrial-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury											
09/89	cate the the the the the the the the the t	that initiated events resulting in death) Last		Du	e to (or as a cor	sequer	ice of):						
×	7 2 4		d										
ô	at the death ce d by the attendii attached for use Physician/												
j.	y the chicked	Part II. Other significant cor	ditions contributing	to death but n	ot resulting in th	e unde	rlying cause give	en in Part I.		23b. Did to			the cause of death?
7	es that igned b be date by Pt									1 U Y	es 220 No	3 Proba	ably 4 ☐ Unknown
ecords,	been s should								_	24a. Was a perlon	n eutopsy ned?	avei	re autopsy findings lable prior to spletion of cause seth?
E	The sate he page									1 □ Y	s 200 No	1 🗆	Yes 2□ No
	Physician: r this cartific rral diractor, rral Gractor,	25. Wes cese referred to me examiner?	-						of Death	(Check only on	e)		
5	this cal dire	1 Yes 20 No	Hospitel:		2 ☐ ER/Outpa			4 LI Nui			nce 6 □Oth		
5	Ing P	27. Manner of Death 1 Ø Natural 5 □ Pe		Date of Injury (Month, Dey Ye	9ar) 28b. Tim Inju	ry	28c. Injun Work			3d. Describe ho	w injury occurr	red	
2	tal or Attanding P rs after death. al Director: After t led in by the funera Certification:	3 Suicide 6 □ Co	vestigation	Dinne of Injury	At home down			Yes 2□N		of Landing (Co			D
3	after Directification	4 ☐ Homicide de	termined 286.	ouilding, etc. (S	- At home, farm Specify)	street,	ractory, office		20	City or Town		er or Hurai i	Route Number,
-	epital ours filled	29a. Certifier 1 Cert	ifying Physician: To	o the best of m	v knowledge d	ath oc	curred at the tim	ne date en	t place, an	ud due to the o	use(s) and ma	noor oo sta	tod
	ne Hospi ne Funer ne Funer pletely fill edical	(Check only 2 Med one)	icai Examiner: On t	he basis of exe manner steted	emination end/o	r invest	igation, in my op	oinion, deat	h occurred	d et the time, d	ate and place, a	and due to the	he cause(s)
	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this cardificate has completely filled in by the funeral director, paga 2: Medical Certification: To Be Compi	29b. Signature end/title of ce	tifier				29c. License	number		2	9d. Date signed	d (Month, D	ay, Yeer)
	-	> W To	Man MI				DI	53	14		Januar	9)	7774
	10	30. Name and eddress of per	son who completed	cause of deeth	n (Item 23e) (Ty	oe, Prin	t) .		1		nuar	7 1, 6	00 7
	Ψ	It Parkas	M7 5	lusons		They	n Che	suf co	he 1	Hospice	, Elkt	35/	004 MD 21921
	State Registrar		v 1 4 2004	32. Registrar's		0	ments.	•				,	

ROBERT	Ρ.	RIDENOUR	State of Maryland / Department of Healt		0 = - 0
		1 - For State Registrar	Certificate of Dea	ath Reg. No. 2004	0003
	hvei	1. Decedent's Name (F	First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death

			1 - State Registrar		Ce	ertificate of	Death	F	Reg. No. 2001	00000
	Physic		1. Decedent's Name (First, Middle, Last Robert Perry RIDEN					2. Date of Dea Month		3. Time of Death 0643 AM
	/Medi Exami		4a. Facility Name (If not institution, give 14170 TOWER ROAD	street and number)			or Location of Dea		4c. County of Dea FREDERI	
1000	Funeral Director		5. Social Security Number 6. Se 220–40–0270	x 7. Aga Mg 2 F	e (In yrs. last birthday 60 Yrs.	Months Days	If Under 24 Hrs Hours Min		9. Bir (1943 Mar	thplace (State or Foreign country) 'yland
	ryland		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	he Ma	Director	Maryland Washing	ton	Hage	rstown				1 ☐ Yes 2 🖾 No
	ath with t	ral Dir	10e. Street and Number 18814 Rolling Roa			10f. Zip Code	21742		USA	ountry?
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23a or 28a-f show shipry or other traumatic event, Ita M-dical Examinar cant be rollined at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent If Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates:	lo	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No		Specify Yes or No- to Rican, etc.)	14. Race - Ame Btack, Whit	
15-0	natu	letec	15. Decedent's Edu (Specify only highest grad	cation le co <i>mpleted)</i>	(Give	edent's Usuat Occup a kind of work done DO NOT use retire	during most of wo	orking	16b. Kind of Business	Industry
212	d within piene. r then	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	nister	0)		church	
	ald be filed a fental Hygie rked other lic event, It	To Be C	17. Father's Name (First, Middle, Last) Raymond Ridenour					me (First, Middle, I	Maiden Sumame)	
, Maryland	ss 1 and 2 should of Health and Men item 27 Is marke other traumatic.		19a. Informant's Name/Relationship (T) Cathy Ridenour -						cown, State, 2	
Baltimore,	permit. Pages 1: Department of He Important: If iten eny injury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)	lemoval from State		osition (Name of imatory or other place cen Cemete			20c. Location - City or Hagerstown	
Balt	permit. Departr Importr eny inj		21. Signature of Funeral Service Licens	Whin	/ /	2. Name and Addre			UNERAL HOM stown, Md.	
	Fnysician /Medical Examiner	ner	23a. Part1. Enter the disease, or compleshook, or heart failure. List only of the shock of heart failure. List only of the shock of the	Due to (or as	the death. Do not ene. Such the function of the consequence of:	A		c or respiratory arm		Approximate Interval Between Onset and Death
68760,	ertificate be executed ang physician and e as the burial-transit	Medicai Examiner	that initiated events resulting in death) Last	Due to (or as a	a consequence of):					
P.O. Box	s that the death certi ned by the att. noing s detached for use a	by Physician/Me	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Ves 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 ☐ Fetal death 3 [□Ectopic pregnancy □ Other (specify) _			23d. Date of deli Month	very Day Year
rds, P	w requires that been signed to should be deta	ed by P	Part II. Other significant conditions con	ntributing to death bu	t not resulting in the u	inderlying cause giv	en in Part I.		pacco use contribute to	
tal Reco	E 25	e Completed	25. Was case referred to medical						y prior to death? death? P□No 1 ¥ Yes	topsy findings available completion of cause of
<u>-</u>	ysicia ils cert directe	To B	examiner?	lospital: 1 Inpatier	nt 2 ☐ ER/Outpatie	nt 3 DOA Oth	-	ath <i>(Check only one</i> Iome 5 Reside	7777	AT SCENE
Division of Vital Records,	tending leath. tor: After the fune	Certification:	27. Manner of Death 1	28a. Date of Injun (Month, Day) Found 113 lo 28e. Place of Injun building, etc.	ry - At home, farm, str	A M 1	at at	28d. Describe ho	w injury occurred Shift reet and Number or Ru , State)	Y Route Number
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical C	29a. Certifier 1☐ Certifying Physical (Check only one) 2☐ Tertifying Physical Examination (Check only one)	sician: To the best of ner: On the basis of and manner stat	examination and/or in	h occurred at the tin vestigation, in my of	ne, date and place pinion, death occu	and due to the 64	use(s) and manner as ite and place, and due	stated. to the cause(s)
	To the H within 24 To the Fi complete	Me	29b. Signature and title of certifier	Kinga	ne)		• number •M•E	29	Od. Date signed (Month JAN • 4 ,	. Day, Year) 2004
	Sta	te	30. Name and address of person who co THE OPOUT M, K 31. Date filed (Month, Day, Year)	_	111 Peni		Baltimo	re, Maryl	and 21201	

State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dev 40 Physician 07 2004 GEORGE HARVEY STANDIFORD January /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner HARFOYD Be MARINER HEATTH-If Under 1 Year if Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days **™** M 2□ F 228-14-077 86 16/1 Director Maryland Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumetic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Harford Forest Hill MD. 10e Street end Number 10f. Zip Code 10g, Citizen of Whet Country? filed within 72 hours after death with 21050 1811 Baldwin Mill Road United States 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc 1 ☐ Yes 2 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: ۾ White 3 ☐ Widowed 4 ☑ Divorced Yeer or Dates: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Harford Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) Groundskeeper 8 Community College 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mantal Hy Important: if Nem 27 is marked oth any Injury or other traumatic event abce. B Standiford Amoss Kinsey Agnes Louise Coe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ida May Houston /Sister 430 Underwood Lane 21014 Bel Air, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1710 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2004 Ebenezer Cemetery Fallston, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee E.G. Kurtz & Son Funeral Home, P.A. Jarrettsville, Maryland 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): The law requires that the daath certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of P.O. Box 68760, pertensun Due to (or as e consequence of)

Physician/Medical Examiner Š Completed or Attending Physician: Be Certification: Director: / after within 24 hours aft To the Funerel DII completely filled In

25. Was cese referred to medical

31. Date filed (Month, Day, Year)

Division of Vital Records,

Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. Was an autopsy performed?

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of deeth?

2 No 1 ☐ Yes 26. Plece of Deeth (Check only one)

1 ☐ Yes 2 ☐ No

	examiner? 1 ☐ Yes 2 No	Hos	spital: 1 Inpatient 2	ER/Outpatient	3□ D	OA Other: 4	Nursing Ho	ome 5 Residence 6 Other (Specify)
2 7 .	2 Accident	Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c. Injury et Work? 1 ☐ Yes		28d. Describe how injury occurred
	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, y)	, facto	ry, office		28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the best of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29b. Signature and title of certifier 29c. License number

ou. & Jun

32. Registrer's Signature

30. Name end address of person who completed ceuse of deeth (Item 23e) (Type, Print) Road SUN ALBERT S. 1716 Harford

State Registrar

edical

		-	For State Registrar	State of Ma	ryland /		irtment of H tificate of L		Mental Hy	giene Reg. No. 20	04	00039
	Physicia	_	1. Decedent's Name (First, Middle, La	st) V .	Stall	ings			2. Date of De Month JANUAR	Day	Year)4	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, giv MEMORIAL HOSPITA				4b. City, Town, or			4c. County	of Deeth	1100
	Funeral Director		5. Social Security Number 6. S	ex 7. Age	(In yrs. last b	irthday) Yrs.	CUMBERLA If Under 1 Year Months Days	If Under 24 H		ALLEGA 21, 1921		ce (State or Foreign
RE	<u> </u>		Usual Residence of Decedent 10a. State MD 10b. County Allega	ny	10c. City, To	or Lo Cum	cation Derland				100	d. Inside City Limits 1 X Yes 2 □ No
	with the Page or 28a-	Funeral Director	10e. Street and Number 362 Bedford Street	et			10f. Zip Code	21502		10g. Citizen of V		y?
036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f ahow other treumatic event, the Medical Examinat man be notified at	by Funera	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 XYes 2 N If Yes, Give Year or Dates:			Vas Decedent of Hi i Yes, specify Cuba	spanic Origin? n, Mexican, Pue Specity:	(Specify Yes or No erto Rican, etc.)		e - Americar k, White, et	c.
Maryland 21215-0036	d within 72 ho giene. or than "natu	Completed by	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12)		,	(Give	lent's Usual Occupa kind of work done of DO NOT use retired CIAN	luring most of w	orking	Schmidt		
/land	buld be filed Mental Hygiarked other atic event, I	To Be C	17. Father's Name (First, Middle, Last George Stalling						ame (First, Middle (Davis)	, Maiden Surnam	е)	
	1 and 2 should Health and Men Ism 27 is marke		19a Informant's Name/Relationship (Type, Print) wife	19	362	Bedford S	ord Number or I	Ru <i>ral Rout</i> e Numb Cum	berland	State, Zin C	ື້າປື້ 21502
Baltimore,	Page nent o ant: If ary or		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Special		20b. Place Sunse	of Dispo Process Mer	sition (Name of natory of other place norial Park	9)	Date 1/10/2004	20c. Location -		n, State MD
Balt	permit. Departr Importe any inji		21. Signature of Funeral Service Lice	Heip	Wi	22	Nam Scarpell 108 Virg		Home, PA ue: Cumbe	erland, MD	21502	
	Pnysician /Medical	8 1	23a. Part1. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Finat disease or condition resulting in death)		e. ARTER	Y DI		g, such as cardi	ac or respiratory a	rrest,	li li	Approximate interval Between Driset and Death YEARS
8760,	Examiner	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a	s consequence	of):						
.O. Box 687	death certif e attending id for use a	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal deat		Ectopic pregnancy Other (specify)			23d. Date Mor	e of delivery nth D	, ay Year
σ	es pe pe	þ	Part II. Other significant conditions	contributing to death bu	t not resulting	in the ur	nderlying cause give	en in Part I.	23e. Did 1	tobacco use contr Yes 2 No		cause of death?
I Records	The law ate has b page 2 si	Completed							24a. Was auto perfo 1 \(\text{Yes}	psy pormed? d	Vere autops prior to comp leath?	y findings available otetion of cause of ☐ No
Vital	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ♣No	Hospital: Inpatie	nt 2 ER/C	lutnation	t 3□ DOA Othe	ar.	eath (Check only of Home 5 Resi		or (Canaily)	
ion of	ding h. After fune	H-1	27. Manner of Death 1 ★Natural 5 Pending 2 △ Accident investigation	28a. Date of Injur (Month, Day	y 28b.	Time of Injury	28c. Injury Work		-	how injury occurre		
Division	lal or Attend is after death el Director: / ed in by the f	Certification:	3 Suicide 6 Could not be determined			farm, str	eet, factory, office		28f. Location (City or To	Street and Numbe wn, State)	er or Rural F	Route Number,
	To the Hospital or Attan within 24 hours after deat To the Funeral Director: completely filled in by the	edicai	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	nysician: To the best of miner: On the basis of and manner sta	examination a	ge, death and/or inv	estigation, in my op	oinion, death oc	ce, and due to the curred at the time,	date and place, a	and due to the	ne cause(s)
)	To the within 2 To the complet	Σ	29b. Signatur, and title of certifier	J. Ban	ery &	2	29c. License	1486	5	JAN, G		•
	4		30. Name and address of person who ROBUSTIANO BARRE				*	UMBERLA	ND,MD 21.	502	200	
	Sta Registi		31. Date filed (Month, Day, Year)		r's Signature		Asserila 9					

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** anua 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner Altimore 7. Age (In rrs. last birthday) JOHNS HO If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 M 2 XF 219-44-0358 56 Director Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10b. County ir than "natural", or Itema 23a or 28a-f show the Medical Examinar must be notified at Allegany Cumberland MD 1 X Yes 2 No Director 10g. Cilizen of What Country? 10e. Street and Number 10f. Zip Code 21502 USA 16 E. Elder Street Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ [XNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 7 is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) hent of Health and Mental H. ht: if item 27 is marked oth. y or other transcent. Be **Dorothy Norris** Pages 1 and 2 should be William Logue 19a. Informant's Name/Relationship (Type, Print)

James Smith 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Gode) 16 E. Elder Street Cumberland MD 21502 husband 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Restlawn Memorial Gardens 1 Burial 2 Cremation 3 Removal from State 1/10/2004 MD Department o Important: if any injury or once. LaVale * 4 ☐ Donation 5 ☐ Other (Specify) 22. Nam Scarbetti Fürreral Home, PA 21. Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 Part 1. There the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock for heart failure. List only one cause on each line. Approximate Interval Betwee Onset and Dea Immediate Cause (Final disease or condition resulting in death) Physician /Medical Tue to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate that I had you cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (on as a consequence of) burialattending physician Division of Vital Records, P.O. Box 68769 Physician/Medical the IF FEMALE: use use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month ģ 4 Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: certificate **2**√2 No 2 XNo 1 Yes 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 2 No 1X Inpatient Certification: To 1 Tes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: / 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, elc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by after 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of gentifier 29c. License number 29d. Date signed (Month, Day, Year) ripleted cause of death (Item 23a) (Type, Print) 30 Name and

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 15

ORIGINAL

32.

2004

Registrar's Signature

		1	State of Maryland / Dep State of Maryland / Dep Registrar State of Maryland / Dep	artment of Health and Mertificate of Death	ental Hygier Reg. N	2001	0081
	0		Negistrar 1. Decedent's Name (First, Middle, Last)	rimodio or Bodin	2. Date of Death		3. Time of Death
	Physicia	ın	MARY F. SUTTON		JANUARY	Say Year 8 2004	2:33p M
James	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
	LAdilliii	3 1	12072 Galena Rd.	Massey		Kent	5
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea		place (State or Foreign intry)
	Director	[:	213-22-5935 1□M 2XF 76 Yrs.		Sept 28	1927 W.	Virginia
_	p ,	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	anyla shov	_					112 Yes 2 □ No
	18a-1	Directo	DE New Castle Newark 10e. Street and Number	10f. Zip Code	100.0	Citizen of What Cou	intry?
	filed within 72 hours after death with the Maryland Hygiene. sther then "neturel", or Items 23a or 28a-f show sht, Ite Medical Examiner must be multified at		5 Daffodil Dr.	19713			,
	eath	Funeral				S · A ·	
	ter d	Ë	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	Rican, etc.)	Black, White	
99	urs al	Ď	3 ☐ Widowed 4 ☑ Divorced Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify:	White
ξ	2 hor	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Giv.	edent's Usual Occupation e kind of work done during most of working	16b.	Kind of Business/Ir	ndustry
2	thin 7	힐	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	P1	astics	
7	ad wil	5	8	sembly Line Work		nufactu	rer
2	m = 0 5	Be	17. Father's Name (First, Middle, Last)		(First, Middle, Maid	en Sumame)	
۶	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other then "neturel", or Items 23a or 28a-1 show eumatic event, the Madical Examiner must be notified at	၉	George Washington Lacy	Emma F.			- C- 4-1
Maryland 21215-0036	12 sh and rism			ling Address (Street and Number or Rura $0 \cdot Box\ 134 Mass$			p Code)
	1 and 1ealt		, ,			Location - City or T	own, Slate
وّ	ages nt of l			ematory or other place) awn Cemetery 1/1	13/04 No	w Cac+1	o DF
Baltimore,	it. Partmer	-					
Ba	permit. Pages 1 and 2 should by Department of Health and Menta Importent: If item 27 is marked any injury or other treumatic enone.			2 Name and Adfress fee at 12 H 18 West Cross S	t. Galer	na, MD.	21635
			23a. Part 1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac o	r respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Cancor			Onset and Death, Z3 Months
	/Medical		resulting in death) Due to (or as a consequence of):				
	Examiner		Sequentially list conditions, b.				
7	De sit	lue	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Examlner	resulting in death) Last C				
8760(be exician lician buria	alE					
687	icate phys	edlcal					
Box (certii nding use a	/W	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deliv	very
	w requires that the death certific been signed by the attending f should be detached for use as	Physiclan/Med	in the past 12 months? 1 Vec 2 MNo 4 Pregnant at time of death 5	☐Ectopic pregnancy ☐ Other (specify)		Month	Day Year
P.O.	t the c	hys	9 Unknown				
	s tha	y P	Part II. Dther significant conditions contributing to death but not resulting in the	underlying cause given in Part I.			the cause of death?
ğ	equire en siç ould t	- Pa	DM 14 poll		1 🗆 Yes	2□No 3□Pro	bably 4 Unknown
900	law re as be	Completed by			24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of
Ě	The ate his	ĕ			performed 1 ☐ Yes 2 €		2□ No
ita	ien: artific ctor,	Be (25. Was case referred to medical examiner?	26. Place of Death	(Check only one)		
<u>></u>	Physicien: this certific ral director,	7	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie		ne 5 🗆 Residence		Mahter's
n c	ing P	on:	27. Manner of Death 1 1 Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury		28d. Describe how in	njury occurred	Home
sio	Attending r death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s		28f. Location (Street	and Number or Rui	ral Route Number
Division of Vital Records,	l or Al after of Direct	Certification;	4 Homicide determined building, etc. (Specify)	niest, iadory, onios	City or Town, St		
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier (Check only 20 Medical Examiner: On the basis of examination and/or in	ath occurred at the time, date and place, a investigation, in my opinion, death occurred	and due to the cause ed at the time, date a	e(s) and manner as and place, and due	stated. to the cause(s)
	o the Hithin 24 o the Formplete	Medi	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29d. jl	Date signed (Month	, Day, Year)
	⊬≽⊬ŏ		► 1008 60000	D 50996	4/	9/04	
	4		30. Name and address of person who completed cause of death (Item 23a) (Type	St. Chastoutous	n MD	21620	5
		ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	St. Chastorton			
	Regist	al	position of				

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

	State of Maryland / Department of Health and N Certificate of Death	, ,	ne 1. No. 2001	00842
Physicia /Medica		2. Date of Death Month JAN • 3,	Day 2004	3. Time of Death 7:10AM
Examine	4a Facility Name (If not institution, give street and number) 4b. City, Town, or Li		4c. County of Death	
	FUTURE CARE PINEVIEW NURSING HOME CLINT		PRINCE C	
Funeral Director	5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 1 M 1 M 2 F 7. Age (In yrs. last birthday) 4 3 Yrs. 1 Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y MARCH 2	9. Birth 6, 1960 N	nplace (State or Foreign IARYLAND
pud * #	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Mary 4 sh	MARYLAND PRINCE GEORGES CLINTON			1 ☐ Yes 2 ☐ No
r 28a	10e. Street and Number 10f. Zip Code	10g	J. Citizen of What Cou	untry?
h with	9106 PINEVIEW LANE 20735		U,S.A.	
ire, Maryland 21215-0020 3.1 end 2 should be filed within 72 hours after death with the Maryland of Health end Mental Hygiene. If Health end Mental Hygiene "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at	MARYLAND PRINCE GEORGES CLINTON 10e. Street and Number 9106 PINEVIEW LANE 11. Marital Status 1 Never Married 3 Widowed 4 Divorced MARYLAND PRINCE GEORGES CLINTON 10f. Zip Code 20735 11. Yes in U.S. Armed Forces? 1 Yes, Give Year or Dates: 1 Yes, Give Year or Dates: 1 Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: BI	, etc.
Maryland 21215-0020 d 2 should be filed within 72 hours aff the nd Mental Hygiene. 7 is marked other than "natural", or traumatic event, the Medical Exam	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) KITCHEN WORKER	ing 16	b. Kind of Business/lo	ndustry
vithi one.	Elementary/Secondary (0-12) College (1-4or 5+) 1 2 KITCHEN WORKER		NURSING	HOME
filed thygin other	17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle, Ma		HOLLE
ylan ould be Mental arked o		E. SMAL	LWOOD	
Aaryla 2 should end Men is marke	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run	al Route Number, C	ity or Town, State, Zi	p Code)
Te, M 1 end 2 Health em 27 i	SHIRLEY SPRIGGS-AUNT 777 HATFIELD COURT	WALDOR	F,MD. 20	602
or oth	20a. Method of Disposition 1 □ Burial 2 ဩ Cremation 3 □ Removal from State	Date 20	c. Location - City or T	own, State
Peges ment of hands it is to to	4 □ Donation 5 □ Other (Specify) METROPOLITAN CREMATORY 1 -	7-04 A	LEXANDRI	A, VA.
Baltimore, N pemit. Peges 1 end Depertment of Health Important: If item 27 any injury or other to	21. Signature of Funeral Service Licensee MOO479 22. Name and Address of Facility RAYMOND FUNERAL			
*	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac			Approximate
Physician /Medical	shock, or heart failure. List only one cause on each the. Immediate Cause (Final disease or condition		1	Interval Between Onset and Death
Examiner	resulting in death) Due to (or as e consequence of):			1
executed on end inel-trensit	, h		i	
687605	Sequentially list conditions, Due to (or as a consequence of).			
68760, ificete be exe g physicien es the buriel.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Cause (Diseas			
687 tificate ig phys es the	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		İ	iii
Beath death death death	Part II. Other significant conditione contributing to death but not resulting in the underlying cause given in Part I.	23h Did tohe	con use contribute t	to the cause of death?
that the de deteched	CLASSIC AND THE STATE OF THE ST	1 ☐ Yes	2. No 3 □ Pro	
	Chronic News for the		7	
Vital Records, P.O. Box sician: The law requires that the death cer certificate has been signed by the ettendir irector, page 2 should be deteched for use		24a. Wes an a performed	d? av	Vere eutopsy findings vailable prior to
law r				ompletion of cause death?
n: The law tificete hes tor, page 2		1 ☐ Yes	2000 1	□Yes 2□No
Vital I	examiner?	n (Check only one)		
thy this ald all the	1 Inpatient 2 EN/Outpatient 3 DOA 4 DATES ing Ho	me 5 Residence	e 6 Other (Speci	fy)
After funer	27. Manger of Death 28e. Dete of Injury 28b. Time of 28c. Injury at Work? 2 Accident investigation M 1 1 Yes 2 No	280. Describe now i	injury occurred	
Division of Vita tal or Attending Physician: is efter death. al Director: After this certificied in by the funeral director.	2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide determined investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	et and Number or Run State)	al Route Number,
Divisor To the Hospital or Atte within 24 hours efter de To the Funeral Directo completely filled in by it		and due to the caus	e(s) and manner as s	stated.
To the H within 24 To the Fi				
To the troom	29b. Signature end title of conflict	29d.	Date signed (Mgnth,	Day, Year)
,	017951		1/3/6	7
3	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	103 7	- Wast	1 (M)
State	21 Date filed (Month Day York) 20 Pariety & Circulus	, , ,	·	gh m)

			1 - For Amend Item# 23b,	State of No., per Dr, C	Maryland (D	epartn 2004 C <i>ertifi</i> t	ent of H	lealth a Death	and M	lental Hy	giene Reg. No	200) 4	008	343
K.	141		1. Decedent's Name (First, Middle, Las		-					2. Date of De Month			rear .	3. Time of	f Death
	Physicia /Medic		Marga	aret A. V	aughan					Januar				1435	РМ
	Examin		4a. Facility Name (If not institution, give	e street and numbe	r)	4b.	City, Town, or	Location of	of Death		40	. County o			
			125 Overbrook La		and the same to an bright	16 I	Elktor Inder 1 Year	lf Under	24 Hrs	8. Date of Bir	•	Ceci.		-lana (Charles	Coming
н	Funeral		5. Social Security Number 6. S	DM 2NE	Age (In yrs. last birth Y		iths Days	Hours	Min.	(Month, Da	y, Year,)	Cou		
	Director		154-22-7904 Usual Residence of Decedent		95 '					AUG 10	, 15	908 1	em	ısylvar	IIa
•	yland yland		10a. State 10b. County		10c. City, Town	or Location	1							10d. Inside C	ity Limits
	a-fs	ţ	New Jersey Camde	en	Colli	.ngswc	ood							1 ∑ Yes	2 🗆 No
	or 28	Director	10e. Street and Number		51	10	f. Zip Code				10g. Ci	tizen of W	nat Cou	ntry?	
	23a	ai	112 Whitman Aven	ue			08108				Ţ	Jnite			
	ar dea	Funerai	11. Marital Status	12. Was Deceder Armed Force:	s?	13. Was E	ecedent of H specify Cuba	ispanic Ori In, Mexicar	gin? (Spe 1, Puerto	ecify Yes or No Rican, etc.)	-		- Ameri White,	can Indian, etc.	
36	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28a-f show the Madical Exerciting to the Invititied at	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates	•	1□Y	es 2∏ No	Specify:				Specify:	TaTh:	ite	
21215-0036	"natural", or	ed	15. Decedent's Ed		16a.	Decedent's	Usual Occup	ation			16b. F	(ind of Bus			
215	nin 72 an "na	Completed	(Specify only highest gra	College (1-4o	r 54)	(Give kind o life. DO N	of work done of OT use retired	during mos t)	t of worki	ng					
212	e filed within al Hygiene. I other than '	E	10	College (1.40	1 01)	Secre	etary				F	Turni	ture	<u> </u>	
멀	be filed within 72 ho ital Hygiene. d other than "natur evant, the Modical	Be C	17. Father's Name (First, Middle, Last))			-	18. Mothe	er's Name	(First, Middle,	Maidel	n Surname,)		
<u>yla</u>		ဥ	Francis Melsheim					Mary	y E.	Warren					
Maryland	s 1 and 2 should f Health and Mer itam 27 is marke other traumatic	w Y	19a. Informant's Name/Relationship (•						i Route Numbe	•			57534	
	s 1 and 2 if Health is itsm 27 is	1	Margaret Reagle, 20a. Method of Disposition	/Daughter	20b. Place of			Lane		kton, I		land			
Baltimore,	00		1 ☐ Burial 2 ☐ Cremation 3 ☐		te cemetery	, cremator	or other place		「anua	ry 6,					
Ξ	it. Pa irimer iriani njury		*4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licer		Harlei				2004				New	Jerse	5Ā.
Ba	permit. Pag Department Important: I any injury o		21. Signature of Full of all colvide close	O bli	10.0					erals,			7	224 21	1021
	4 1 5 7		23a. Part1. Enter the disease, or com	plications that caus	ed the death. Do no					reet, E		OII , . I'ld	зкАт	Approximat	te
V.	Pnysician		shock, or heart failure. List only Immediate Cause (Final										7	Onset and	Death
	/Medical		disease or condition resulting in death)		Failure	f):								.0 Year	<u>.s</u>
	Examiner		Constitution and bines	b. Arterio	osclerosis										
-	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		as a consequence o	f):									
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Hyperte	ension as a consequence o	0.									
8760,	cate be executed ohysician and the burial-transit	ai E	is country and country and country	Due to (or a	is a consequence o	1).									
387		dicai		_ d											
Box 6	leath certifi attending I I for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcon	ne of pregnancy							23d. Date	of deliv	өгү	
) <u>m</u>	death a atter	ciar	in the past 12 months? 1 ☐ Yes 2 ☒ No	4□Pregnant	2 Fetal death at time of death		oic pregnancy or (s <i>pecify)</i>	'				Mont	h	Day	Year
P.O.	that the de led by the a	hys	9 Unknown	9□ Unknown											
	res tha igned be det		Part II. Other significant conditions of	-	but not resulting in	the underly	ing cause giv	en in Part I		23e. Did t	obacco			he cause of o	
rd	w require been sign should t	ed	Arterioscleros	is						10,	Yes 2	.⊠No 3	Prot	bably 4 □l	Unknown
Vital Records,	e lawre has be je 2 shi	Completed by	Old Age							24a. Was autop	osy	pri	or to co	opsy findings impletion of c	available cause of
E		Con								perfo	rmed? 2 🂢 No		ath?]Yes	2 🗆 No	
/ita	ician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?	11			0#		-	(Check only o					
o	Physician: this certific ral director,	မ	1 Yes 2 No	Hospital: 1 ☐ Inpa			DOA Oth		_	me 5 🗆 Resid				Wall of the	er's
n C	Jing F	ion	1 XNatural 5 ☐ Pending		jury 28b. Ti Da <i>y Year)</i> In	jury M	28c. Injur Wor	yan' k? Yes 2 🗀		zou. Describe r	now inju	ny occurred	,		
Division	Attending ir death. ector: After by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	e gen Place of	Injury - At home, far		3		-	28f. Location (or Rura	al Route Num	nber,
Θ	al or A after Dire d in b	Certification;	4 Homicide		etc. (Specify)		•			City or Tov	wn, Stat	θ)			
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral	Medical C			st of my knowledge, of examination and stated.										s)
	To the To the To the complex	Me	29b. Signature and title of certifier	hh	,011	4/7	29c. Licens	e number	,	7	29d. Da	te signed	Month,	Day, Year)	,
) Come	10 XV	nus VII	Y,	12	.48	5 X		0	1/6	15	104	
	-		30. Name and address of person who	completed cause o	f death (Item 23a) (Type, Print)			-						
	5		Robert L. Smith,			aph I	Road, E	Elktor	n, Ma	aryland	219	21			
	Sta Registr		31. Date filed (Month, Day, Year)		strar's Signature	and the same	Cont	3							

			1 - For Stata Registrar	State of Maryla		tment of F		ental Hygier	2001	00844
	Dharatat		1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	ay Year	3. Time of Death
	Physicia /Medic		THERESA	ANN	WARH	OLA		January	7, 200	04 8:48 A M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	r Location of Death	4	c. County of Dea	
		_	Upper Chesapeak			Bel			Harí	
	Funeral		5. Social Security Number 6. Sex	IM APPIE	. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	g. Bir	thplace (State or Foreign ountry)
	Director		<u> </u>	4	6 Yrs.			6/3/19	7 Per	nsylvania
	and *		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Loca	ation				10d. Inside City Limits
	danyl f sho	ō	MD. Harf	6 ma			Bel Air	,		1 ☐ Yes 2 XNo
	the !	Director	10e. Street and Number	OI a		10f. Zip Code	Del Hil		Citizen of What Co	ountry?
	death with the Maryland ms 23e or 28a-f show Fright ke rightfind at	۵		ost Court			21015		nited S	
do	leath ms 2:	Funerai		12. Was Decedent Ever in	J.S. 13. W	as Decedent of H	lispanic Origin? (Spean, Mexican, Puerto F		14. Race - Ame	
348	ufter or ita	Ē	1 X Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ANo				Rican, etc.)	Black, Whi	te, etc.
0.36	ral', c	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	11	□Yes 2□ X No	Specify:		Specify:	<i>l</i> hite
ر 215-0036	72 hc	Completed	15. Decedent's Edu (Specify only highest grade	cation e completed)	16a. Decede	nt's Usual Occup	ation during most of working	16b.	Kind of Business	/Industry
2	ithin Ban	idπ	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of working Reside	197-198	- 7 - 1 - 0	1
22	led w lygier hartt	S	12	2	Progr	am Co-c	<u>ordinato</u>		ealth C	are
1/	be fill H dot	Be	17. Father's Name (First, Middle, Last)					(First, Middle, Maide		
~ <u>8</u>	ould Mer Marke narke	ဥ	Stephen		Warh		Rose	Lee		lzio
a l	12 sh 12 sh 1 and 7 is n		19a. Informant's Name/Relationship (Ty				and Number or Rura			
. 0	1 and 1 and 1 and 1 and 2 1 and 2 1 har		Rosemarie S. Ku 20a. Method of Disposition				Post Ct		Alr. N. Location - City or	Id . 21015
35 W	iges in its or of		1 ☐ Burial 2 🛣 Cremation 3 🗆 🖯			tion (Name of story or other place			·	
35	t. Pa rtmer rtant rjury		'4 □Donation 5 □Other (Specify)	White Ro	se Cre	matori	$am \mid 1/9/$	2004 You	ck, Per	msylvania
393500 1/7	permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Protection 1 and 2 and 1 a		21. Signature of Funeral Service License	" H H I	· -	Name and Addres	0 4	rrettsv		
#			23a Part 1 Enter the disease or compli	cations that caused the des			rtz & So		al Home	Approximate
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final	0			ig, such as cardiac of	respiratory arrest,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		ndoc	robbig				1 ways
	Examiner			Due to (or as a conse	quence of):	11				Market 1
		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	quence 1:	Lami				fen
000	uted	Examiner	Cause (Disease or injury that initiated events							
O. C.	execution and ital-trans	Exa	resulting in death) Last	Due to (or as a conse	quence of):					
)92	ate be executed sysician and he burial-transi	icai								
19 68		edi								
Warhola	h cer endir use	N/L	230. Was decedent pregnant	3c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet		ctopic pregnancy			23d. Date of de	livery
2	deal deatt	Sicie	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	4 Pregnant at time of		Other (specify)			Month	Day Year
Warhola P.O. Box 6876	at the	hy				-				
	ires that the death certific signed by the attending p d be detached for use as	by Physician/Med	Part II. Other significant conditions con	tributing to death but not re	sulting in the und	erlying cause give	en in Part I.			the cause of death?
4nn Records.	The law requires that the death certificate has been signed by the attending plage 2 should be detached for use as t	Completed		**	· · · · · ·			1 ∐ Yes	2 L x(No 3 □ Pr	robably 4 Unknown
4nn Reco	law r las be	pie						24a. Was an autopsy	24b. Were at	utopsy findings available completion of cause of
4 =	The ate h	50						performed? 1 ☐ Yes 2 🗷 N	death? lo 1 ☐ Yes	2 □ No
Vital	Attanding Physician: The lay releast actor: After this certificate has yet the funeral director, page 2	Be	25. Was case referred to medical examiner?				26. Place of Death			
£ 2	hysi this c	ို	1 195 2 NO	lospital: 1 🔀 Inpatient 2	The second of	3□ DOA Othe	er: 4 Nursing Hom			cify)
89	ding Phys	on:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		8d. Describe how inj	ury occurred	
sic	uttandi death. ctor: A y the fu	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		1	1/4	Yes 2 □ No	Of Landing (Chart		
heresa Division of	or Al ufter of Dirac in by	Certification:	4 ☐ Homicide determined	28e. Place of Injury - At I building, etc. (Spec	ify)	t, factory, office	2	8f. Location (Street a City or Town, Sta	te)	urai Houte Number,
F	spital		29a. Certifier 1 🗷 Certifying Phys	sicien: To the best of my kn	owledge death	occurred at the tim	ne date and place a	nd due to the causel	e) and manner as	stated
	s Hos 24 h a Fun etely	Medicai		ner: On the basis of examin and manner stated.	ation and/or inve	stigation, in my or	pinion, death occurre	d at the time, date a	nd place, and due	to the cause(s)
	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Lunaral Director: After this certificate has completely filled in by the funeral director, page 2	Me	29b. Signature and title of certifier			29c. License			ate signed (Mont	h, Day, Year)
	1) (Souther	with ,	M.D.	D	0047813		January	7 2004
	5		30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type, Pi	rint)			A A	
_			BASHAR KA	mpleted cause of death (Ite	20 4/	ser Che!	saprake 1)	14. Jule 21	1)2119	11 17 21014
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	4 See	M 27 -			

Lindsay Adger 04-00337 crn

			Chain of Mondane	1/Danaman	at of Hoolth and I	Montal Liveria	0.0	
		= For Unpend Item#23a Registrar	, Part II, 27, Per M	E, 6828, 2/13/ Certifica	te of Death	vientai Hygiei Reg.	2004	0084
		1. Decedent's Name (First, Middle, Last,)			2. Date of Death Month	Day Yeer	3. Time of Death
Physic /Medi	cal	4a. Fecility Name (If not institution, give	street and number)	ADG.	ER , Town, or Location of Deat	January 1	3, 2004 4c. County of Death	12:32 P
Exami	ier	701 N. Arlington			Baltimore		N/A	
Funeral Director		5. Social Security Number 6. Se 12/3-36-4363	X M 2□ F 7. Age (In yrs. Ia	5 Yrs. If Under Months	or 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Ye		place (State or Forentry) THCAROLI
within 72 hours after death with the Maryland ene. than "naturel; or Itama 23a or 28a-f show he Medical Exeminer must be notified at	tor	10a. State 10b. County	10c. City,	, Town or Location	BALTIM	ORE C	177	1 XYes 2 1
or 28s	Funeral Director	10e. Street and Number		10f. Zi	ip Code	10g.	Citizen of What Cour	•
er death with Itsms 23s or Definant be	eral	11 2 9 WEST	12. Was Decedent Ever in U.S	7 5/,	adent of Hispanic Origin? (S	23 pecify Yes or No-	US 14. Race - Americ	, ,
s 1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mental Hygiene. item 27 is marked other than "naturel", or Itama 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	If Yes, spe	edent of Hispanic Origin? (Secify Cuban, Mexican, Puert 2 th No Specify:	o Rican, etc.)	Specify 3	
72 hours aft "naturel", or	eted I	15. Decedent's Edu (Specify only highest grad	ucation	16a. Decedent's Usu (Give kind of w	ual Occupation ork done during most of wor	rking 16b	. Kind of Business/In	dustry
within ane. then "	Completed	Elementary/Secondary (0-12)	Callege (1-4ar 5+)	1 ,	ork done during most of wor use retired) 35 HoREM		TEAMSHIF	TOANS
should be filed within ad Mental Hygiene. marked other then imatic event, the M.	Be Co	17. Father's Name (First, Middle, Last)	1	20100		ne (First, Middle, Maid		1144
should be nd Mental marked c umatic eve	To B	FLEMING	A	DGER	GLAL	1/5		ENSON
1 and 2 sho Health and Iem 27 is my other traumy		19a. Informant's Name/Relationship (T) PATRICIA GAITH	TER (NEICE)	1037	is (Street and Number or Ru W. LOMB,	ARDST.	by or Town, State, Zip BHLTO, I	(Code)
00		20a. Method of Disposition	Removal from State	ace of Disposition (Na emetery, crematory or	ame of other place)	Date 20c	Location - City or To	own, State
permit. Pag Department Important: I any injury o		21. Signature of Euneral Service Licens	1.11		and Address of Highlity	ROWN TH	2. FUNER	AL Hon
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the death.	. Do not enter the mo	ode of dying, such as cardiac	or respiratory arrest,	71270116	Approximate Interval Between
nysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Atherosclerot:		cular Disease			Onset and Death
Examiner	<u>.</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	ence of):				
ured d ansit	Examiner	cause (Disease or injury that initiated events						
te be executed ysician and ie burial-transit	cal Exa	resulting in death) Last	Due to (or as a consequent	ence of):				
entificat ling phy e as th		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar				23d. Date of delive	
ns o								ery
y the attend ched for us	ysicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown				Month	ery Day Year
juires that the death certificate be executed n signed by the attending physician and lid be detached for use as the burial-transit	d by Physician/Med	1 ☐ Yes 2 ☐ No	4 Pregnant at time of de 9 Unknown	ath 5 Other (s	specify)	23e. Did tobacc	Month to use contribute to the	Day Year
aw requires is been sign 2 should be	completed by Physicia	1 Tes 2 No 9 Unknown Part II. Other significant conditions co	4 Pregnant at time of de 9 Unknown	ath 5 Other (s	specify)	1 ☐ Yes 24a. Was an autopsy performed	Month co use contribute to th	Day Year ne cause of death pably 4 Minkno posy findings availa mpletion of cause
The law requires ate has been sign page 2 should be	Completed	1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions co Chronic Alcoholism 25. Was case referred to medical	4 Pregnant at time of de 9 Unknown	ath 5 Other (s	cause given in Part I.	1 ☐ Yes	Month co use contribute to th	Day Year ne cause of death pably 4 Minkno posy findings availa mpletion of cause
ysiciant. The law requires is certificate has been sign director, page 2 should be	To Be Completed	1	4 Pregnant at time of de 9 Unknown ontributing to death but not result the special of the specia	ath 5 Other (s	cause given in Part I. 26. Place of Dea	1 Yes 24a. Was an autopsy performed 1 Yes 2 ath (Check only one)	Month co use contribute to th	Day Year ne cause of death pably 4 Minknot posy findings availa mpletion of cause 2 No
ysiciant, interiaw requires is certificate has been signi director, page 2 should be	To Be Completed	1 Yes 2 No 9 Unknown Part II. Other significant conditions co Chronic Alcoholism 25. Was case referred to medicat examiner? 12 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	4 Pregnant at time of de 9 Unknown ontributing to death but not result the special of the specia	ath 5 ☐ Other (s	cause given in Part I. 26. Place of Dec	1 Yes 24a. Was an autopsy performed 1 Yes 2 Ath (Check only one)	Month co use contribute to th	Day Year ne cause of death' pably 4 Junkno
ysiciant. The law requires is certificate has been sign director, page 2 should be	To Be Completed	1 Yes 2 No 9 Unknown Part II. Other significant conditions co Chronic Alcoholism 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	4 Pregnant at time of de 9 Unknown ontributing to death but not resulting	iting in the underlying ER/Outpatient 3 D 28b. Time of Injury M me, farm, street, factor	cause given in Part I. 26. Place of Dea OOA Other: 4 \(\text{ Nursing H} \) 28c. Injury at Work? 1 \(\text{ Yes} \) 2 \(\text{ No} \)	1 Yes 24a. Was an autopsy performed 1 Yes 2 ath (Check only one)	Month to use contribute to the course contribute to the course contribute to the course cour	Day Year The cause of death' Dably 4 Junkno Spsy findings availate The properties of cause
ysiciant. The law requires is certificate has been sign director, page 2 should be	Certification: To Be Completed	1 Yes 2 No 9 Unknown Part II. Other significant conditions co Chronic Alcoholism 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined 29a. Certifier 1 Certifying Phy	4 Pregnant at time of de 9 Unknown ontributing to death but not result the solution of the so	ER/Outpatient 3 Description of Injury Memo, farm, street, factory	cause given in Part I. 26. Place of Dec 26. Place of Dec 27. Other: 4 \(\text{Nursing F} \) 28c. Injury at Work? 1 \(\text{Yes} \) 2 \(\text{No} \) iry, office d at the time, date and place	1 Yes 24a. Was an autopsy performed 1 Yes 2 ath (Check only one) lome 5 Residence 28d. Describe how in 28f. Location (Street City or Town, St	Month to use contribute to th	Day Year ne cause of death' pably 4 Minknot pay findings avail mpletion of cause 2 No Vat scen
Attending Physician: The law requires r death. setor: After this certificate has been sign by the funeral director, page 2 should be	To Be Completed	Part II. Other significant conditions co Chronic Alcoholism 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 2 Natural investigation 3 Suicide determined 29a. Certifier Certifying Phy (Check only 2 Medicel Exam	4 Pregnant at time of de 9 Unknown Ontributing to death but not result to the sum of th	ER/Outpatient 3 D 28b. Time of Injury M me, farm, street, facto	cause given in Part I. 26. Place of Dec 26. Place of Dec 27. Other: 4 \(\text{Nursing F} \) 28c. Injury at Work? 1 \(\text{Yes} \) 2 \(\text{No} \) iry, office d at the time, date and place	24a. Was an autopsy performed 1 Yes 2 at (Check only one) tome 5 Residence 28d. Describe how in 28f. Location (Street City or Town, St.	Month to use contribute to th	Day Year ne cause of death? pably 4 Unknown posy findings availating the cause 2 No No No No No No No No No No
ysician: The law requires is certificate has been sign director, page 2 should be	Certification: To Be Completed	Part II. Other significant conditions co Chronic Alcoholism 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 2 Natural investigation 3 Suicide determined 29a. Certifier (Check only one) 29b. Signature and title of certifier	Hospital: 1 Inpatient 2 E 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At hor building, etc. (Specify, ysician: To the basis of examination and manner stated.	The street factor of the stree	26. Place of Dec 26. Place of Dec OCA Other: 4 \(\text{ Nursing } \) 28c. Injury at Work? 1 \(\text{ Yes} \) 2 \(\text{ No} \) ory, office d at the time, date and place in, in my opinion, death occur.	24a. Was an autopsy performed 12 Yes 2 □ ath (Check only one) dome 5 □ Residence 28d. Describe how in 28f. Location (Street City or Town, Street at the time, date 29d.	Month co use contribute to th	Day Year ne cause of death? pably 4 Unkno posy findings availa mpletion of cause 2 No No No No No No No No No No
ysician: The law requires is certificate has been sign director, page 2 should be	Certification: To Be Completed	Part II. Other significant conditions co Chronic Alcoholism 25. Was case referred to medical examiner? 1	Hospital: 1 Inpatient 2 E 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At hor building, etc. (Specify, ysician: To the basis of examination and manner stated.	ER/Outpatient 3 D 28b. Time of Injury M me, farm, street, facto vieldge, death occurred ion and/or investigation 23a) (Type, Print)	26. Place of Dec 26. Place of Dec 27. Other: 4 \(\text{Nursing } \) 28c. Injury at Work? 1 \(\text{Yes} \) 2 \(\text{No} \) 10 \(\text{Yes} \) 2 \(\text{No} \) 10 \(\text{Yes} \) 2 \(\text{No} \) 11 \(\text{Yes} \) 2 \(\text{No} \) 12 \(\text{Yes} \) 2 \(\text{No} \) 13 \(\text{Yes} \) 2 \(\text{No} \) 14 \(\text{Yes} \) 2 \(\text{No} \) 15 \(\text{Yes} \) 2 \(\text{No} \) 16 \(\text{Yes} \) 2 \(\text{No} \) 17 \(\text{Yes} \) 2 \(\text{No} \) 17 \(\text{Yes} \) 2 \(\text{No} \) 18 \(\text{Yes} \) 2 \(\text{No} \) 19 \(\text{Yes} \) 2 \(\text{Yes} \) 20 \(\text{Yes} \) 2 \(\text{Yes} \) 21 \(\text{Yes} \) 2 \(\text{Yes} \) 22 \(\text{Yes} \) 23 \(\text{Yes} \) 24 \(\text{Yes} \) 25 \(\text{Yes} \) 26 \(\text{Yes} \) 27 \(\text{Yes} \) 28 \(\text{Yes} \) 29 \(\text{Yes} \) 26 \(\text{Yes} \) 27 \(\text{Yes} \) 28 \(\text{Yes} \) 29 \(\text{Yes} \) 29 \(\text{Yes} \) 20 \(\text{Yes} \) 20 \(\text{Yes} \) 20 \(\text{Yes} \) 20 \(\text{Yes} \) 20 \(\text{Yes} \) 20 \(\text{Yes} \) 20 \(\text{Yes} \) 20 \(\text{Yes} \) 20 \(\text{Yes} \) 20 \(\text{Yes} \) 30 \(\text{Yes} \) 40 \(\text{Yes} \) 40 \(\text{Yes} \) 40 \(\text{Yes} \) 40 \(\text{Yes} \) 40 \(\text{Yes} \) 40 \(\text{Yes} \) 40 \(\text{Yes} \) 40 \(\text{Yes} \) 40 \(\text{Yes} \) 40 \(\text{Yes} \) 40 \(\text{Yes} \) 40 \(\text{Yes} \) 40 \(\text{Yes} \) 40 \(\text{Yes} \) 40 \(\text{Yes} \) 51 \(\text{Yes} \) 52 \(\text{Yes} \) 53 \(\text{Yes} \) 53 \(\text{Yes} \) 54 \(\text{Yes} \) 55 \(\text{Yes} \) 75 \(\text{Yes} \) 75 \(\text{Yes} \) 75 \(\text{Yes} \) 75 \(\text{Yes} \) 75 \(\text{Yes} \) 75 \(\text{Yes} \) 75 \(\text{Yes} \) 75 \(\text{Yes} \) 75 \(\text{Yes} \) 75 \(\text{Yes} \) 75 \(\text{Yes} \) 75 \(\text{Yes} \) 75 \(\text{Yes} \) 75 \(\text{Yes} \) 75 \(\text{Yes} \) 75 \(\text{Yes} \) 76 \(\text{Yes} \) 77 \(\text{Yes} \) 77 \(\text{Yes} \) 77 \(\text{Yes} \)	1 ☐ Yes 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ ath (Check only one) tome 5 ☐ Residence 28d. Describe how in 28f. Location (Street City or Town, Signard at the time, date 29d. 26d. J6d.	Month to use contribute to the course contribute to the course contribute to the course of the cour	Day Year ne cause of death? pably 4 Minkno ppsy findings availa mpletion of cause 2 No 2 No At SCED at Route Number, tated. to the cause(s) Day, Year) 2004

			- FOI	partment of Health and Nertificate of Death	nental Hygiei Reg.	- / HILL HIRDE
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
•	Physici	_	Waltraud Avent		JANUAR)	Day Yeer 4 2:25 A.M
-	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
	- DAGITI		Union Memorial Hospital	Baltimore		N/A
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	// If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	9. Birthplece (State or Foreign Country)
	Director		215-32-0436 1□M 2♥F 76 Yrs.	North Suy Suy Suy Suy Suy Suy Suy Suy Suy Suy	April 24,	1927 Germany
	D .		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or	ocation		10d. Inside City Limits
	ehor	5				1∭Yes 2□No
	the N	Director	Martifland N/A 10e. Street and Number	Baltimore 101. Zip Code	100	Citizen of What Country?
	a or			21206	1.03	U. S. A.
	eath	Funeral	4608 Eugene Avenue 11. Marital Status 12. Was Decedent Ever in U.S. 13. Marital Status		pecify Yes or No-	14. Race - American Indian,
	ter d	ᇤ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	Was Decedent of Hispanic Origin? (Sp. 1f Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
99	urs a	by	3 💢 Widowed 4 □ Divorced If Yes, Give 🔨 Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: White
Õ	2 ho	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Girls)	edent's Usual Occupation	king 16b	b. Kind of Business/Industry
2	thin 7	nple	Elementary/Secondary (0-12) College (1-4or 5+)	re kind of work done during most of work DO NOT use retired)	9	
7	ed wi	Co	4 Yeasis	Homemaker		Own Home
p	be filed within 72 hours after death with the Maryland lat Hygiene. d other then "natural", or iteme 23e or 28e-f ehow event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maid	deri Sumame)
yla	ould Men Marke	2	Walter Reher	Minna		
Mar	l 2 sh h and 7 is n			iling Address (Street and Number or Ru		
e,	s 1 and 2 of Health a Item 27 is		20a Method of Disposition 20b, Place of Dis	Schooner Lane, Mi		Location - City or Town, Stete
20	nt of		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, ca	ematory or other place)	10001 30	Limore, Maryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "naturat", or Iteme 23a or 28a-f ehow any injury or other treumatic event, the Medical Examiner must be notified at Ance.			Ly Redeemer 1/16/ 22. Name and Address of Facility Sc		
Ba	Depa Impo any i			3331 Brehms Lane,		
			23a. Pert Enter the disease, or complications that caused the deeth. Do not eshoot, or hear failure. List only on cause on each line.			
П	Dhysisian					Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	1+C/1+C/ 1-/+1	LURE	TAEVAS
	Examiner					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury			
	cuted nd ransi	Examiner	that initiated events c.			
Ó,	e exe	Ĕ	resulting in death) Last Due to (or as a consequence of):			
8760,	death certificate be executed the attending physicien and ad for use as the burial-transit	dicai	d			
9	ertific ling p e as	0	IF FEMALE:			
Box	eath certifi attending I for use as	lan/		Ectopic pregnancy		23d. Date of delivery Month Day Year
o.	the de	yslc	1 Yes 2 100 4 Pregnant at time of death 9 Unknown	6 Other (specify)		
P.O.	that the de led by the a detached i	by Physician/M	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
of Vital Records,	Se Lo	d b	RENAL INSUFFICIENCY,		1 🗆 Yes	2 No 3 Perbably 4 Unknown
50		ete	PULMONARY HYPERTENSION	0.6	24a. Was en	24b. Were autopsy findings available
Re	The law ete has b page 2 sl	Completed	TO CE TO THE PORT OF THE PORT	V	autopsy	d? prior to completion of cause of death?
a	ilcian: Th certificete rector, pag	e Co	25. Was case referred to medical	26 Place of Dea	1 ☐ Yes 2 ☐	No 1 Yes 2 Li No
Ē	Physician: r this certificantal director.	To B	examiner? 1 Yes 2 No Hospital: 1 Impatient 2 ER/Outpat	Othor		ce 6 ☐Other (Specify)
	g Phy er thi	Ë	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	28d. Describe how	
ion	Attending ir death. ector: After by the fune	atlo	1 ☐Natural 5 ☐ Pending (Montin, Day Year) Injury 2 ☐ Accident investigation	M 1 Yes 2 No		
Division	r Atte er de recto by th	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
Ö	ital or ris aft rel Di					
4	To the Hospital or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer.	edical	29a. Certifier (Check only (C	ath occurred at the time, date and place investigation, in my opinion, death occu	e, and due to the caus irred at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
	the hin 2 the mplet	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29d	. Date signed (Month, Day, Year)
	N N N		Dan lluman range 197			
,	11/		700000000000000000000000000000000000000	Driet) 201 5-1	1/dia 2/4	~
	10		30. Name and address of person who completed cause of death (Item 23a) (Type Toy EAT PUTHUMBING INVON)	MEMORIALISED.	BALTI	MORE, NOD 21212
	Sta	te				
	Registr	-	JAN 1 6 2004 Frances	1. Brails		

State of Maryland / Department of Health and Mental Hygiene 2004 State AMEND ITEM #8 PER FH G829 3/29/04 Julertificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 2004 anuan EVELYN LAVERNE AMBERG /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimevel If Under 1 Year If Under 24 Hrs. MCCir Birthplace (State or Foreign Country) 8. Date of Birth 1915 (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Months Days **Funeral** Hours 1 □ M 2XXF 89 Yrs. MARYLAND Director 220-14-4496 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County r than "natural", or Items 23a or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes XX No BALTIMORE MARYLAND BALTIMORE Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number UNITED STATES 3300 BENSON AVENUE, APT. 111 21227 OF AMERICA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes XXNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after 1 Never Married 2 Married Specify: 1 ☐ Yes XX No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: þ XXWidowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education be filed within 72 (Specify only highest grade completed) th and Mental Hygiene.

7 Is marked other than traumatic event, Inc. Me. Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARY WOLZ ပ HENRY WENNER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 nent of Health an nt: if item 27 is 1 CHARLES TOWN, WEST VIRGINIA 25414 42 PEMBROKE GROVE; ALVIN LEROY AMBERG (SON) 20b. Place of Disposition (Name of cometery, crematory or other place)
BALTIMORE CREMATORY
COUDON PARK Date 20c. Location · City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or BALTIMORE, MARYLAND * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility LOUIDIN PARK FUNERAL 3620 WILKENS AVENUE 21. Signature of Funeral Service Licensee Chmain an O. BALTIMORE, MARYLAND Red1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respirator HOUN Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed the attending physician and the for use as the burial-tran Due to (or as a consequence of): by Physiclan/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month 5 Other (specify) detached O 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed Records, pe 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? (es 212 No page 2 2 No 1 Yes 1 🗌 Yes Vital 26. Place of Death (Check only one) in by the funeral director, 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1. Inpatient 2 ER/Outpatient 3 DOA 2 o 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Division 5 Pending Injury 1. Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide To the Hospitel o within 24 hours aft To the Funeral Di completely filled 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier burrany 10, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Ketty Inomas MU actor 31. Date-filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Œ		1 - For Unpend Item # 23a.	State of Maryla	nd / Dep	artment of He	ealth and	Mental Hy	giene	0.01	00010	1
			,2,,200 T per m	Ce	htificate of D	Death	2. Date of Dea		004	3. Time of Death)_
Physic	ian	1. Decedent's Name (First, Middle, Last)		۸1 هـ			Month JANUAR	Day	Year 2004	м	
/Med Exami		Jennifer Eli 4a. Facility Name (If not institution, give str	zabeth reet and number)	<u>Ault</u>	4b. City, Town, or I	Location of Deat			nty of Death	2:15P. "	_
Exam.	1161	9248 BELLBECK ROA	AD		PARKVII				'IMORE		
Funera		5. Social Security Number 6. Sex	M 24DF	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Da			ace (State or Foreign try)	
Director		Usual Residence of Decedent	48				July 9,	1955	New	Jersey	_
death with the Maryland me 23s or 28e-f show Lives be notified at		10a. State 10b. County		ity, Town or Lo					10	Od. Inside City Limits	
Be-f s	Director	Maryland Baltimore	ва	ltimor					()40	1 ☐ Yes 2 ☐ No	
with the		10e. Street and Number	- 3		10f. Zip Code 21234			USA	of What Count	uyr	
Jeath The 23	Funeral	9248 Bellbeck Ros	2. Was Decedent Ever in t	U.S. 13.	Was Decedent of His	spanic Origin? (S	Specify Yes or No	14. F	Race - America		_
after or ite		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		If Yes, specify Cuban 1 ☐ Yes 2 ₩ No		to Hican, etc.)		Black, White, e city: Wh	ite	
ING 21213-UU36 be filed within 72 hours after death with the Marylan Ital Hygiene. d other than "natural", or items 23a or 28e-f show event, the Modical Examiner or ast be notified at	d by	3 □ Widowed 4 ☑ Divorced	Year or Dates:	16a Dasa					, 1111		_
within 72 I ene.	Completed	15. Decedent's Educa (Specify only highest grade	completed)	(Give	dent's Usual Occupat kind of work done du DO NOT use retired)	urina most of wo	rking	16b. Kind o	f Business/Ind	iosity	
a filed within the hygiene.	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	Pa	ralegal			Law	Firm		
be filed ntal Hygind other	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden Sun	ame)		
	ပ	Jesse Lou:			ng Address (Street a	Jean		City of To	Abb		_
0 0 2 0		19a. Informant's Name/Relationship (Type Jean A. Ault (Mothe			ox 134, Gi					C00 0)	
re, N s 1 and f Health item 27 other tr	1	20a. Method of Disposition	20b.	Place of Dispo	osition (Name of	,	Date	20c. Location	on - City or Tox	wn, State	
Baltimore, permit. Pages 1 at Department of Hea Importent: If Item any injury or othe		1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	moval from State Ba	ltimor Loudon	matory or other place Cremator Park	y 1/1	2/04	Baltim	ore, M	aryland	
Salt semit. epartn sports ny inje		21. Signature of Funeral Service Lice			2. Name and Address						
		23a. Part1. Enterthe disease, or complic	ations that as used the de-		3620 Wilke				D 2122	Approximate	4
	4	shock, or heart failure. List only one Immediate Cause (Final	e cause on each line.			, 30011 43 041014	o or roophatory an	1001,		Interval Between Onset and Death	
Physiciar /Medica		disease or condition resulting in death)	Isopropanol Due to (or as a conse		tion						-
Examine		Sequentially list conditions	30								
sit ad	lner	Sequentially list conditions, b. tay, leading the indicate cause. Enter Undertying Cause (Disease or injury	Due to (or as a cons-	quence of):							
y xecut n and al-tran	Examin	that initiated events resulting in death) Last	Due to (or as a conse	equence of):					-		i
\$8760, icate be executed physician and s the burial-transit	cal	d.									
	Medi	IF FEMALE:				-					1
Box 68 leath certifics attending pl	Physician/Med	23b. Was decedent pregnant in the past 12 months?	Ic. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fe	tal death 3	Ectopic pregnancy				Date of deliver Month	ry Day Year	i A
P.O. I that the de ted by the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Cinknown	4□Pregnant at time of 9□ Unknown	oeath 5t	Other (specify)						
Records, P.O. Box 68 The law requires that the death certifica the has been signed by the attending ph page 2 should be detached for use as it	by Ph	Part II. Other significant conditions cont	ributing to death but not re	esulting in the t	underlying cause give	n in Part I.	23e. Did to	bacco use c	ontribute to th	e cause of death?	
cords require been sig							101	es 2 No	3 Proba	ably 4 Unknown	
Records, he law requires t e has been signe tge 2 should be o	Completed						24a. Was autop	sy	b. Were autop prior to con	osy findings available inpletion of cause of	
	Con							rmed? 2 No	1 Li Yes	2 No	
> = 0 5	o Be	25. Was case referred to medical examiner? 14 Yes 2 □ No	ospital:	☐ ER/Outpatie	othe		ath <i>(Check only o</i> Home 5 ☐ Resid		that (Canait	d management	
Physeratidis	 -	27. Manner of Death	28a Date of Injury	28b. Time		at 2	28d. Describe I			SCFNE	
ision (Mending I death. ctor: After	atio	1 Natural 5 Pending 2 Accident Investigation	Found th, Day Year) 1/10/04	Found ^{ury} 1:56	p M 1□Y	es 2 X No	Unknown				
Division of i or Attending Physalter death. Director: After this in by the tuneral d	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, st city)	reet, factory, office				78°BéIIB	eck kd.	
Div Hospitel or A 24 hours after Funerel Dire		29a. Certifier 1 ☐ Certifying Physi	Found at hom ician: To the best of my ki		th occurred at the time	e. date and plac	Parkvi11		manner as st	ated.	
Division of To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical	(Check only one) Medical Examin	er: On the basis of examinand manner stated.	nation and/or i	nvestigation, in my op	inion, death occ	urred at the time,	date and place	e, and due to	the cause(s)	
To th within To th	×	29b. Signature and title of certifier	011		29c. License	number		29d. Date sig	ned (Month, L	Day, Year)	
	- Walter	Mounte In	elhell	- hu	0.C.	M.E.	i c	JANUAR	Y 11,20	004	
		30. Name and address of person who cor	4	em 23a) (Type	111 Penn	Street	Baltimo	re Ma	hae farr	21201	
* <u>\$</u>	tate	31. Date filed (Month, Day, Yas)	Ange CC	nature	-	rocked	TATE CHIED	LC, FIG	гатапа	7170T	-
Regis		JANT	- CUU4	127.	March March	Carlotte John					

		•	For State Registrar		State of Marylan		nt of Health and te of Death		ene 2001	00849
,	Physici /Medic Examin	al er	1. Decedent's Name 4a. Fecility Name (If r 5. Social Security Num	S. Coh not institution, give str Habbles	reel and number) A DRIVE 7. Age (In yrs.	2	r, Town, or Location of De		Day 2004 4c. County of Deat	3. Time of Death 2.00 P M h h h h h h place (Stete or Foreign
	Funeral Director	5	384-07-1 Usuel Residence of D	7338 101	M 252F 8	3 Yrs. Months			920 Ren	10d. Inside City Limits
	the Maryli r 28a-f sho	rector	10e. Street and Numb	Harlos	d	000A 101. Z	ip Code	10	g. Citizen of What Co	1 □ Yes 2 No untry?
9	within 72 hours after death with the Maryland ene. Than "hatural", or Nems 23a or 28a-f ahow 're Medical Examiner must be notified at	by Funeral Director	11. Marital Status	d 2 Married	2. Was Decedent Ever in U Armed Forces? 1 _ Yes _ 2 No If Yes, Give	S. 13. Was Dec	21085 edent of Hispanic Origin? ecity Cuban, Mexican, Pui 212No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Ame Black, White	
21215-0036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artment of Heatin and Mental Hygiene. ortent: if Item 27 is marked other than "natural; or Items 23a or 28a-f ahow injury or other traumatic avent, the Medical Examinar must be notified at injury or other traumatic avent, the Medical Examinar must be notified at	Completed by	3 Widowed 4 (Specify Elementary/Second	15. Decedent's Educa y only highest grade	Year or Dates:	16a. Decedent's Us	ual Occupation rork done during most of w use retired)	vorking	6b. Kind of Business/	Industry
Maryland 2	hould be filed of Mental Hygist marked other matic avent, if	To Be C	17. Father's Name (F	irst, Middle, Last)	Simocki		1001-01	Rural Route Number.	likush	Zin Code)
_	Pages 1 and 2 sho nent of Health and int: If Item 27 is m iry or other traum		Konald 20a. Method of Dispo	LF (OK	30 - SON 206. F	Place of Disposition (Nemetery, crematory of	LARAC TR	ail Bal	SIMORI,	MD 21220 Town, State
Baltimore,	permit. Page Department o Importent: If any injury or once.			S □ Other (Specify) eral Service Licensee	Wells	22. Name Reace	MARCH AIR and Address of Facility J	2004 1 1325 YORK YKVEZ FUN	CREST FIELD RQ TIMO LRQ + Cler	NIUM, MD M. CENTER
	Pnysician /Medical		23a. Part1. Enter the shock, or heart Immediate Cause (F disease or condition resulting in death)	failure. List only one final	ations that caused the deat e cause on each line.	d myou	doe of dying, such as card	iac or respiratory arres	st.	Approximate Interval Between Onset and Death MINISCULE
	be executed sicien and purial-transit	Examiner	Sequentially list con- fl any, leading to im- cause. Enter Under Cause (Disease or in that indiated events resulting in death) La	lying lijury c.	Sue/to/or as a conseq Due to (or as a conseq	pidemi	a .			343
.O. Box 68760	ath certificate ittending physor use as the	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 n 1 □ Yes 2 □ 9 □ Unknown	pregnant ponths?	ic. If yes, outcome of pregnation to the body of the b	il death 3 □Ectopic			23d. Date of deli Month	ivery Day Year
٥.	v requires that been signed b should be deta	Completed by Ph	/ /	porosis	ributing to death but not res	ulting in the underlying	rcause given in Part I.	1 ☐ Yes	24b. Were au	obably 4 Unknown
Vital Re	icien: certifică ector, l	o Be Com	25. Was case referred examiner?	H	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	Other	autopsy perform 1 Yes 2 Death (Check only one 5 Resider	ed? death?	
Division of Vital Records,	ttending death. ctor: After y the fune	Certification: To	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide		28a. Date of Injury (Month, Day Yeer) 28e. Place of Injury - At h building, etc. (Speci	28b. Time of Injury M ome, farm, street, fact	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	v injury occurred	
1	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Medical Ce			icien: To the best of my kni er: On the basis of examina and manner stated.					
	To the vithin 2 To the comple	Me	29b. Signature and I	us fel	20		D:31093		d. Date signed (Monti	•
	St	ate	30. Name and addre	Pross	mpleted cause of death (Item ADM D 7 4 32. Registrars Sign	m 23a) (Type, Print) 2 Joje produce artire	D31093	Joppa,	MD 2-10	85

State of Maryland / Department of Health and Mental Hygiene 2 1 1 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death January Physician 2004 Dorothy Bloecker 10:00p M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Fairhaven Sykesville Carroll If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Aug 1 1905 6 Sax 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 XF 98 Yrs. 088-07-9390 PÃ Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other then "neturel", or Items 23a or 286-1 show treumetic event, the Medical Examinar must be mailtied at Sykesville 1 ☐Xes 2 ☐ No Md Carrol1 Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7200 Third Avenue 21784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours atter 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No Specify: δ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) AT & T district supervisor permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 1s marked othe any injury or other treumette event, once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nellie Allen Enos William Julius Bloecker ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 Mercury Rd., Newark, DE 19711 Catherine B. Nelson (niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) All County Cremation | 1-16-04 Sykesville, Md 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Nayl suand P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complicatione that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pegenerative **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of, Examiner or Attending Physicien: The law requires that the death certiticate be executed after death.

Director: After this certiticate has been signed by the attending physician and in by the tuneral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 1∐ Yes 2 XNo 2 🗆 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 vursing Home 5 Residence 6 Other (Specify) ٥ 1 ☐ Yes 2 🔀 🗓 o 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel L Haspitel 29a. Certifier 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature/and title of certifier DZZZZZ January 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sykesville, Md 21784 ELLIS MEZ M.D. 7200 Third Ave 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

	- 1	_ State Registrar	State of Maryla	Certi	ificate of De	eatn		Reg. No.		0000
		1. Decedent's Name (First, Middle,	Last)				2. Date of De	eath Day	Year	3. Time of Death
Physicia		Mary Ann Becker					JANUAR		2004	5 : 25 P
/Medic		4a. Facility Name (If not institution, g			4b. City, Town, or Lo	cation of Death		4c. Co	unty of Death	
Examine	er	PAINT AGNES	HEGGTH CATE	=	BALT	TIMORI	Ē		N/A	
		3 1111		yrs, last birthday)		f Under 24 Hrs.	8. Date of Bi	rth		place (State or Foreigntry)
uneral		216-03-4113	1□M 2XF 90		Months Days	Hours Min.	Apr. 2	а <i>у, Үваг)</i> 4. 191	3 Czec	hoslovaki.
irector	-	Usual Residence of Decedent	7.				mpr	1, 1,1	5 0200	HODIOVAKI
*	1	10a. State 10b. County	10c.	. City, Town or Loca	ation					10d. Inside City Limit
유명	5	n 1.	•		Catonsvil:	1.				1 ☐ Yes 2X N
ir featur and welvent hygeries and resured; or items 23e or 28e-f show titem 21 is marked other than "natural; or items 25e or 28e-f show other traumatic event, the Madical Examinar must be notified at	Funeral Director		imore		10f. Zip Code	1e		10a Citizen	of What Cou	ntry?
2 2	吉	10e. Street and Number						rog. oniao.		,.
23a	<u>a</u>	707 Maiden Choi				21228			ited S	
E B	ne	11. Marital Status	12. Was Decedent Ever i Armed Forces?	in U.S. 13. Wa	as Decedent of Hispa Yes, specify Cuban,	anic Origin? (S) Mexican, Puert	pecify Yes or No D Rican, etc.)	0- 14.	Race - Americ Black, White,	
	교	1 ☐ Never Married 2 ☐ Marrie	d 1 □ Yes 2 ☐MNo If Yes, Give			Specify:			ecify:	
E	þ	3 XWidowed 4 ☐ Divorced	Year or Dates:						Wh	ite
E afric	Completed	15. Decedent's	Education	16a. Decede	nt's Usual Occupation	on ina most of wor	kino	16b. Kind	of Business/In	idustry
돌혈	e e	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO	O NOT use retired)	ing most or nor	g			
E 5	E	12	College (1-401 51)	P	harmacy T	echnici	an	D	rug St	ore
ther.	Ö	17. Father's Name (First, Middle, La	ast)		18	B. Mother's Nan	ne (First, Middle	, Maiden Su	rname)	
0 p	Be	Frank Novotny				Mar	ie Adam	ek		
park patio	ပ္			105 Mailia	Address (Street and				oum State Zir	n Code)
nue ma		19a. Informant's Name/Relationshi	ip (Type, Print)							00000)
n 27 ar tr		Frederick J. Be			neberry C	ourt, G				
item 27 othar tra		20a. Method of Disposition	20	b. Place of Disposi cemetery, crema	ition (Name of atory or other place)	İ	Date	20c. Locat	tion - City or T	own, State
t: H y or		1 ☑ Burial 2 ☐ Cremation 3	3 ∐Removal from State N	Meadowrid Memorial	atory or other place) ge Park	1-12	-2004	Flkri	dge, M	D
in in		41. Signature of Funeral Service Li	1		Name and Address					
Important: If its any injury or o once.		21. Signature of Fullera Convice Di	CV VIII	11 V 2 X/II						
= 60		July may	DIAMPANA		28 Sulphu				s, MD	
		23a. Part 1. Enter the disease, or c shock, or heart failure. List o	complications that caused the conty one cause on each line.	death. Do not enter	r the mode of dying,	such as cardiad	or respiratory	arrest,		Approximate Interval Between
ician	9	Immediate Cause (Final	COMFE	CTIUE 1	HEALET F	WI LUR	£			Onset and Death
dical		disease or condition resulting in death)				-				0
			Due to for as a con							All and the
nıner			Due to (or as a con	nsequence of):						1 YEL
uner	_	Sequentially list conditions,	b. ISCHEW	nsequence of):	CHUNO					1 454
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	9.61	nsequence of):						1 45+
	aminer	that initiated events	b. 15C + 5 W Due to (or as a cor	nsequence of):						1 48#
and I-transit	Examiner	Cause (Disease of Injury	b. ISCHEW	nsequence of):						1 454
sician and e burial-transit	icai Examiner	that initiated events	b. 15C + 5 W Due to (or as a cor	nsequence of):						1 454
sician and e burial-transit	edicai	Cause (Disease of Injury that initiated events resulting in death) Last	b. 15C + 5 W Due to (or as a cor	nsequence of):						1 YEA
sician and e burial-transit	edicai	Cause (Disease of Injury that initiated events resulting in death) Last	b. Due to (or as a cord. Due to (or as a cord.	nsequence of): nsequence of): nsequence of):	c 17VLISIO			230	d. Date of deliv	1 YEA
for use as the burial-transit	edicai	Gause (Disease of Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths?	b. Due to (or as a cord. Due to (or as a cord. 23c. If yes, outcome of print of the cord.	nsequence of): nsequence of): nsequence of): regnancy Fetel death 3 □E	C (TVL IS/O			230	d. Date of deliving Month	1 YEA
for use as the burial-transit	edicai	Cause (Disease of Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	b. Due to (or as a cord. Due to (or as a cord.	nsequence of): nsequence of): nsequence of): regnancy Fetel death 3 □E	c 17VLISIO			23c		•
by the avenue projection and tached for use as the burial-transit	edicai	Cause (Disease of Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	b. Due to (or as a cord. Due to (or as a cord. 23c. If yes, outcome of prilipre birth 2 14 Pregnant at time 9 Unknown	nsequence of): nsequence of): nsequence of): regnancy Fetel death 3 □E of death 5 □	Ectopic pregnancy Other (specify)	ung u p	EHTA		Month	Day Year
gned by the attending physician and be detached for use as the burial-transit	Physician/Medical	Cause (Disease of Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	b. Due to (or as a cord. Due to (or as a cord. 23c. If yes, outcome of prilipre birth 2 14 Pregnant at time 9 Unknown	nsequence of): nsequence of): nsequence of): regnancy Fetel death 3 □E of death 5 □	Ectopic pregnancy Other (specify)	ung u p	23e. Did	tobacco use	Month	Day Year
gned by the attending physician and be detached for use as the burial-transit	by Physician/Medical	Cause (Disease of Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	b. Due to (or as a cord. Due to (or as a cord. 23c. If yes, outcome of prilipre birth 2 14 Pregnant at time 9 Unknown	nsequence of): nsequence of): nsequence of): regnancy Fetel death 3 □E of death 5 □	Ectopic pregnancy Other (specify)	ung u p	23e. Did		Month	Day Year
been signed by the attending priysical and should be detached for use as the burial-transit	by Physician/Medical	Cause (Disease of Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	b. Due to (or as a cord. Due to (or as a cord. 23c. If yes, outcome of prilipre birth 2 14 Pregnant at time 9 Unknown	nsequence of): nsequence of): nsequence of): regnancy Fetel death 3 □E of death 5 □	Ectopic pregnancy Other (specify)	ung u p	23e. Did	tobacco use	Month contribute to to the second of the s	Day Year the cause of death? bably 4 Unknow
has been signed by the attending physician and ge 2 should be detached for use as the burial-transit	by Physician/Medical	Cause (Disease of Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	b. Due to (or as a cord. Due to (or as a cord. 23c. If yes, outcome of prilipre birth 2 14 Pregnant at time 9 Unknown	nsequence of): nsequence of): nsequence of): regnancy Fetel death 3 □E of death 5 □	Ectopic pregnancy Other (specify)	ung u p	23e. Did 1 = 24a. Wa aut	tobacco use	Month contribute to to to to to to to to to to to to to	the cause of death? bably 4-Unknown opsy findings availal ompletion of cause of
has been signed by the attending physician and ge 2 should be detached for use as the burial-transit	Completed by Physician/Medical	Gause (Disease of Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a cord. Due to (or as a cord. 23c. If yes, outcome of prilipre birth 2 14 Pregnant at time 9 Unknown	nsequence of): nsequence of): nsequence of): regnancy Fetel death 3 □E of death 5 □	Ectopic pregnancy Other (specify)	in Part I.	23e. Did 1 = 24a. Wa autr 1 = Yes	tobacco use Yes 2 1 s an ppsy formed? 22 No	Month contribute to to to to to to to to to to to to to	Day Year the cause of death? bably 4 Unknot
uifcate has been signed by the attending physician and or, page 2 should be detached for use as the burial-transit	Be Completed by Physician/Medical	Cause (Disease of Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	b. Due to (or as a cord. C. Due to (or as a cord. 23c. If yes, outcome of prince of prince of the pregnant at time of the program of the pregnant at time of the pregnant at	nsequence of): nsequence of): regnancy Fetel death 3 E	Ectopic pregnancy Other (specify) derlying cause given	in Part I.	23e. Did 1 = 24a. What auto per 1 = Yes ath Check onle	tobacco use Yes 2 1 s an ppsy formed? 2 No	Month contribute to to to to to to to to to to to to to	the cause of death? bably 4 Unknow opsy findings availal ompletion of cause of
is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit	Be Completed by Physician/Medical	Gause (Disease of Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant condition	b. Due to (or as a cord. C. Due to (or as a cord. 23c. If yes, outcome of pridiciple birth 2 4 Pregnant at time 9 Unknown Instructions to death but not the price birth 2 1 time 1 ti	nsequence of): nsequence of): nsequence of): regnancy Fetel death 3 E of death 5 of death	Ectopic pregnancy Other (specify) derlying cause given	in Part I. 26. Place of Dec	23e. Did 1 = 24a. What autous per 1 = Yes ath Check onleading 5 = Res	tobacco use Yes 2 1 s an 2 ppsy formed? 22No one sidence 6	Month contribute to to to to to to to to to to to to to	the cause of death? bably 4 Unknow opsy findings availal ompletion of cause of
this certificate has been signed by the attending physician and all director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 27. Manner of Death	b. Due to (or as a cord. C. Due to (or as a cord. 23c. If yes, outcome of provided in the second of the second o	nsequence of): nsequence of): nsequence of): regnancy Fetel death 3 E of death 5 of death	Ectopic pregnancy Other (specify) derlying cause given	in Part I. 26. Place of Dec	23e. Did 1 = 24a. What auto per 1 = Yes ath Check onle	tobacco use Yes 2 1 s an 2 ppsy formed? 22No one sidence 6	Month contribute to to to to to to to to to to to to to	the cause of death? bably 4 Unknoopsy findings availabmpletion of cause of
After this certificate has been signed by the attending physician and tuneral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Gause (Disease of injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 □ Yes 2 □ No	b. Due to (or as a cord. Due to (or as a cord. 23c. If yes, outcome of principle	nsequence of): nsequence of): nsequence of): regnancy Fetel death 3 E of death 5 of death	Ectopic pregnancy Other (specify) derlying cause given 28 3 DOA Other. 28c. Injury a Work?	in Part I. 26. Place of Dec	23e. Did 1 = 24a. What autous per 1 = Yes ath Check onleading 5 = Res	tobacco use Yes 2 1 s an 2 ppsy formed? 22No one sidence 6	Month contribute to to to to to to to to to to to to to	the cause of death? bably 4 Unknow opsy findings availal ompletion of cause of
Alter this certificate has been signed by the attending physician and tuneral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Cause (Disease of Injury that initialted events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to (or as a cord. C. Due to (or as a cord. 23c. If yes, outcome of pridicing birth 2 downward. 4 Pregnant at time 9 Unknown In scontributing to death but not patient 28a. Date of Injury (Month, Day Year) 28a. Place of Injury 28a. Place of Injury 28a. Place of Injury	nsequence of): nsequence of): nsequence of): regnancy Fetel death 3 Et of death 5 of death 5 of death 5 of death 5 of death 5 At resulting in the uncompanient of the unc	Ectopic pregnancy Other (specify) derlying cause given 23 3 DOA Other. 28c. Injury a Work? M 1 Ye	in Part I. 26. Place of Deat 4 \(\text{Nursing F} \)	23e. Did 1 = 24a. What autous per 1 = Yes ath Check onleading 5 = Res 28d. Describe	tobacco use Yes 2 1 s an 2 ppsy formed? 2 No one sidence 6 2 how injury of	Month contribute to to to to to to contribute to to to contribute to to to to to to to to to to to to to	the cause of death? bably 4 Unknoopsy findings availabmpletion of cause of
Director; After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	Cause (Disease of Injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown Part II. Other significant condition 25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No 27. Manner of Death 1 □ Metural 5 □ Pending investig	b. Due to (or as a cord. C. Due to (or as a cord. 23c. If yes, outcome of prince of the pregnant at time of the pregnant at	nsequence of): nsequence of): nsequence of): regnancy Fetel death 3 Et of death 5 of death 5 of death 5 of death 5 of death 5 At resulting in the uncompanient of the unc	Ectopic pregnancy Other (specify) derlying cause given 23 3 DOA Other. 28c. Injury a Work? M 1 Ye	in Part I. 26. Place of Deat 4 \(\text{Nursing F} \)	23e. Did 1 = 24a. What autous per 1 = Yes ath Check onleading 5 = Res 28d. Describe	tobacco use Yes 2 1 s an ppsy formed? 22 No one sidence 6 0 how injury of	Month contribute to to to to to to contribute to to to contribute to to to to to to to to to to to to to	Day Year the cause of death? bably 4 Unknown opsy findings availation opsy findings availation opsy findings availation opsy findings availation opsy findings availation opsy findings availation opsy findings availation
Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	Certification; To Be Completed by Physician/Medical	Cause (Disease of Injury that initialted events resulting in death) Last	b. Due to (or as a cord. C. Due to (or as a cord. Due to (or as a cord. 23c. If yes, outcome of properties of Injury (Month, Day Year building, etc. (S)	nsequence of): nsequence of): nsequence of): regnancy Fetel death 3 E of death 5 of tresulting in the unce 2 ER/Outpatient ar) 28b. Time of Injury At home, farm, stre	Ectopic pregnancy Other (specify) derlying cause given 23 DOA Other: Work? M 1 Ye et, factory, office	in Part I. 26. Place of Dec 4 \(\text{Nursing H} \)	23e. Did 1 24a. What autoper 1 Yes ath Check onleading 5 Res 28d. Describe	tobacco use Yes 2 1 s an opsy formed? 2 No one sidence 6 1 b how injury of own, State)	Month contribute to 1 No 3 Pro 24b. Were auth prior to oc death? 1 Yes Other (Speci	the cause of death? bably 4 Unknown oppsy findings availal ompletion of cause of 2 No al Route Number,
Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	Certification; To Be Completed by Physician/Medical	Cause Disease of Injury that initialted events resulting in death) Last	b. Due to (or as a cord. C. Due to (or as a cord. 23c. If yes, outcome of prince of the pregnant at time good of the pregnant at t	nsequence of): nsequence of): nsequence of): regnancy Fetel death 3 Death of death 5 Death of death 5 Death of death 5 Deat	Ectopic pregnancy Other (specify) derlying cause given 28c. Injury a Work? M 1 Ye et, factory, office	in Part I. 26. Place of Dead 4 Nursing Hatt	23e. Did 1 24a. Wa aut put put put put put put put put put p	tobacco use Yes 2 1 s an 2 ppsy formed? 22 No one sidence 6 0 how injury of (Street and A own, State)	Month contribute to to to to to to to to to to to to to	the cause of death? bably 4 Unknow opsy findings availat ompletion of cause of 2 No ify) ral Route Number,
Director; After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	Certification; To Be Completed by Physician/Medical	Cause Disease of injury that initiated events resulting in death) Last	b. Due to (or as a cord. C. Due to (or as a cord. 23c. If yes, outcome of principle of the pregnant at time good unknown. Hospital: 1 compatient 28a. Date of Injury (Month, Day Yeal) 28a. Place of Injury building, etc. (S) general of the basis of exal and manner stated.	nsequence of): nsequence of): nsequence of): regnancy Fetel death 3 Death of death 5 Death of death 5 Death of death 5 Deat	Ectopic pregnancy Other (specify) derlying cause given 28c. Injury a Work? M 1 Ye et, factory, office occurred at the time, estigation, in my opin	in Part I. 26. Place of Dec. 4 \(\text{Nursing F} \) the set 2 \(\text{No} \)	23e. Did 1 24a. Wa aut put put put put put put put put put p	tobacco use Yes 2 1 s an ppsy formed? 2 No one sidence 6 (Street and Nown, State) e cause(s) are, date and pl	Month contribute to to to to to to to to to to to to to	the cause of death? bably 4 Unknow opsy findings availat ompletion of cause of 2 No ify) ral Route Number, stated. to the cause(s)
this certificate has been signed by the attending phy: al director, page 2 should be detached for use as the	To Be Completed by Physician/Medical	Cause Disease of Injury that initialted events resulting in death) Last	b. Due to (or as a cord. C. Due to (or as a cord. 23c. If yes, outcome of principle of the pregnant at time good unknown. Hospital: 1 compatient 28a. Date of Injury (Month, Day Yeal) 28a. Place of Injury building, etc. (S) general of the basis of exal and manner stated.	nsequence of): nsequence of): nsequence of): regnancy Fetel death 3 Death of death 5 Death of death 5 Death of death 5 Deat	Ectopic pregnancy Other (specify) derlying cause given 23 DOA Other: Work? M 1 Ye et, factory, office occurred at the time, estigation, in my opin 29c. License r	in Part I. 26. Place of Dec 4 Nursing Hat as 2 No , date and place number	23e. Did 1 24a. Wha auti 1 Yes ath Check onl Home 5 Res 28d. Describe 28f. Location City or To	tobacco use Yes 2 1 s an opsy formed? 2 No one sidence 6 (b how injury of own, State) e cause(s) ar o, date and pl 29d. Date s	Month contribute to 1 No 3 Pro 24b. Were auth prior to or death? 1 Yes Other (Special Contribute or Run and manner as a stace, and due to signed (Month,	the cause of death? bably 4 Unknow opsy findings availabe ompletion of cause of 2 No fiy) al Route Number, stated. to the cause(s)
Director; After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	Certification; To Be Completed by Physician/Medical	Cause Disease of injury that initiated events resulting in death) Last	b. Due to (or as a cord. C. Due to (or as a cord. 23c. If yes, outcome of principle of the pregnant at time good unknown. Hospital: 1 compatient 28a. Date of Injury (Month, Day Yeal) 28a. Place of Injury building, etc. (S) general of the basis of exal and manner stated.	nsequence of): nsequence of): nsequence of): regnancy Fetel death 3 Death of death 5 Death of death 5 Death of death 5 Deat	Ectopic pregnancy Other (specify) derlying cause given 23 DOA Other: Work? M 1 Ye et, factory, office occurred at the time, estigation, in my opin 29c. License r	in Part I. 26. Place of Dec 4 Nursing Hat as 2 No , date and place number	23e. Did 1 24a. Wha auti 1 Yes ath Check onl Home 5 Res 28d. Describe 28f. Location City or To	tobacco use Yes 2 1 s an opsy formed? 2 No one sidence 6 (b how injury of own, State) e cause(s) ar o, date and pl 29d. Date s	Month contribute to 1 No 3 Pro 24b. Were auth prior to or death? 1 Yes Other (Special Contribute or Run and manner as a stace, and due to signed (Month,	the cause of death? bably 4 Unknow opsy findings availabe ompletion of cause of 2 No fiy) al Route Number, stated. to the cause(s)
Director; After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	Certification; To Be Completed by Physician/Medical	Cause (Disease of Injury that initialted events resulting in death) Last	b. Due to (or as a cord. C. Due to (or as a cord. 23c. If yes, outcome of provide to the pregnant at time and the pregnant at time at	regnancy Fetel death of death of death of death of death st resulting in the und 2 ER/Outpatient ar) 28b. Time of Injury At home, farm, stre pecify) y knowledge, death umination and/or invo	Ectopic pregnancy Other (specify) derlying cause given 23 DOA Other: Work? M 1 Ye et, factory, office occurred at the time, estigation, in my opin 29c. License r	in Part I. 26. Place of Dec 4 Nursing Hat as 2 No , date and place number	23e. Did 1 24a. Wha auti 1 Yes ath Check onl Home 5 Res 28d. Describe 28f. Location City or To	tobacco use Yes 2 1 s an opsy formed? 2 No one sidence 6 (b how injury of own, State) e cause(s) ar o, date and pl 29d. Date s	Month contribute to 1 No 3 Pro 24b. Were auth prior to or death? 1 Yes Other (Special Contribute or Run and manner as a stace, and due to signed (Month,	the cause of death? bably 4 Unknow opsy findings availabe ompletion of cause of 2 No fiy) al Route Number, stated. to the cause(s)
Director; After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	Certification; To Be Completed by Physician/Medical	Cause Disease of injury that initiated events resulting in death) Last	b. Due to (or as a cord. C. Due to (or as a cord. 23c. If yes, outcome of provide to the pregnant at time and the pregnant at time at time and the pregnant at time at time at time at time at time at time at time at time at time at time at time at time at time at time at time at time at time at	regnancy Fetel death of death of death of death of death st resulting in the und 2 ER/Outpatient ar) 28b. Time of Injury At home, farm, stre pecify) y knowledge, death umination and/or invo	Ectopic pregnancy Other (specify) derlying cause given 23 DOA Other: Work? M 1 Ye et, factory, office occurred at the time, estigation, in my opin 29c. License r	in Part I. 26. Place of Dec 4 Nursing Hat as 2 No , date and place number	23e. Did 1 24a. Wha auti 1 Yes ath Check onl Home 5 Res 28d. Describe 28f. Location City or To	tobacco use Yes 2 1 s an opsy formed? 2 No one sidence 6 (b how injury of own, State) e cause(s) ar o, date and pl 29d. Date s	Month contribute to 1 No 3 Pro 24b. Were auth prior to or death? 1 Yes Other (Special Contribution of Run nd manner as a stace, and due to signed (Month,	the cause of death? bably 4 Unknow opsy findings availat ompletion of cause of 2 No ify) ral Route Number, stated. to the cause(s)

DHMH 17 Rev 1/2001

MITTER

DHMH 17 Rev 1/2001

			For State Registrar		State of I	Marylar		artment of F			_	giene Reg. No.	004	00853	
	Physicia		1. Decedent's Nam	ne (First, Middle,	Last)		-				2. Date of De Month	Dav	Year	3. Time of Death	
,	/Medic	al	Richar		Joseph		Ва	uman			Januar	y 13	2004	10:00 p M	
	Examin	er			give street and number		v a b	4b. City, Town, o		of Death			inty of Death	rundel	
			5. Social Security I		our Health		lab •	Annapo		24 Hrs.	8. Date of Birt	th	9 Birth		
	Funeral Director		579-36	-7014	1 ∑ MM 2□F	76	Yrs.	Months Days	Hours	Min.	April	12,192	7 Was	place (State or Foreign intry) Shington DC	
	/land		10a. State	10b. County	-	10c. Ci	ty, Town or Lo	ocation						10d. Inside City Limits	
	Man,	ţ	MD	Anne A	Arundel		Shady	Side						1 ☐ Yes 2 💢 No	
	n the	lrec	10e. Street and No	ımber				10f. Zip Code				10g. Citizen	of What Cou	intry?	
	th wi	a D	5234 C	hesapeal	ke Avenue			2076	64			US	A		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if time 21 is marked other than "natural" or Itams 23a or 28a-f show any injury or other traumatic evant, the Modical Examinations to Indiffer at once.	by Funeral Director		ried 2000 Marrie	12. Was Decede Armed Force ed 1 Tes 2 If Yes, Give Year or Date	ΩNo	1	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2XXNo	lispanic Or an, Mexica Specify:		ecify Yes or No Rican, etc.)		Race - Amer Black, White acify:		
ဗို	2 hou	ed		15. Decedent			16a. Dece	dent's Usual Occup	ation			16b. Kind <i>o</i>	f Business/I	ndustry	
215	hin 7:	Completed	(Spe Elementary/Sec		grade completed) College (1-4c	or 5+)	(Give	kind of work done DO NOT use retired	during mos d)	it of work	ing				
7	ad witt giene ar the	E C			4		Draft	sman					d Tay	lor	
Maryland 21215-0036	al Hy al Hy 1 oth	Be (17. Father's Name	(First, Middle, L	.ast)						e (First, Middle,		name)		
Х	ould be f Mental I Marked of Matic eva	ပ္		M. Baur			_	i			e Donne				
<u>lar</u>	2 sh and 1s m	11	19a. Informant's N					ng Address (Street						·	
esî Os	t and tealth nm 27 ther t		Edith 20a. Method of Dis		an (Wife)	20h		Chesapeal			, Shady	Side,			
Baltimore,	in of h		1 XBurial 2	☐ Cremation	3 □Removal from Sta	re l		osition (Name of matory or other place							
ቜ	it. Pa		* 4 ☐ Donation 21. Signature of F	5 Other (Sp	+4	Ga		Heaven Co			/2004		r Spr	ing, MD	
Ba	Depa Impo any i		21. Signature of	The services	icerisee		-	Name and Addre					D 21//	0.1	
			23a. Part1. Enter	the disease, or o	complications that cause	sed the dea	th. Do not ent	12 Ridge:					D 2140	Approximate	
	Physician		shock, or he Immediate Cause disease or conditi resulting in death)	(Final	only one cause on each	ulul	a G	lon Go	rumo	ma		-		Interval Between Onset and Death	
	/Medical Examiner		rosaling in doday		Due to (or	as a consec	quence of):								
	po iis	iner	Sequentially list c if any, leading to i cause. Enter Und Cause (Disease o	onditions, mmediate erlying	b Due to (or	as a consec	quence of):							· · · · · · · · · · · · · · · · · · ·	
	The law requires that the death certificate be executed te has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Examiner	that initiated event resulting in death)	S	c. Due to (or	as a consec	tuence of):								
8760,	be ex ician burial	E	,		500 10 (51	as a consec	querios oi).								
387	physicate s the	dlc			d										
9 X	that the death certific ed by the attending p detached for use as	Physician/Medical	IF FEMALE:	at expanset	23c. If yes, outcor	ne of pregn	ancy					23d	Date of deliv	rerv	
Box	death a atter	clar	in the past 12	2 months?	1 ☐ Live birth			∃Ectopic pregnancy ∃ Other (specify)	<u>'</u>				Month	Day Year	
o.	t the c by the achec	hysl	9 ☐ Unknow		9□ Unknow	1									
ر. ح	uires that signed t d be det	by P	Part II. Other sign	ificant condition	ns contributing to deat	n but not res	sulting in the u	nderlying cause giv	en in Part l	l.	23e. Did to	obecco use c	ontribute to	the cause of death?	
ğ	w require been sig should b	edt									101	∕es 2□No	3 ☐ Pro	bably 4 Dunknown	
Vital Records,	aw requisits peen	Completed									24a. Was		b. Were aut	opsy findings available ompletion of cause of	
æ	The lay ate has bage 2	E									autop perfo 1 ☐ Yes	rmed?	death?	2 No	
ā	iici an : Th certificate rector, pag	Be C	25. Was case refe	erred to medical		26. Place of Deal					th (Check only one)				
	Phyaician: this certificantal director, i	101	1 ☐ Yes 2 🖸	No		Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho						ome 5 Residence 6 Other (Specify)			
ב	ding P h. After t funera	ü	27. Manner of Dea 1 Natural	5 Pending	28a. Date of I (Month,	njury Day Year)	28b. Time o Injury	Wor			28d. Describe h	now injury occ	curred		
sio	Attanding it death. ector: After by the funer	catl	2 ☐ Accident 3 ☐ Suicide	investig 6 □ Could n	ation of he			-	Yes 2□						
Division of	I or Attanater death after death Director: I in by the	Certification:	4 ☐ Homicide	determi	and 286. Place of	etc. (Speci	iome, farm, sti fy)	reet, factory, office			28f. Location (S City or Tox		ımber or Rur	al Route Number,	
	To the Hospital or Attanding Physician: The lawithing 4 bours after death, within 24 bours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier	1 Certifying	Physicien: To the be	st of my kn	owledge, deat	h occurred at the tir	ne, date ar	nd place,	and due to the	cause(s) and	manner as :	stated.	
K	ha Ho n 24 t ha Fu pletely	edical	(Check only one)	2 Medicel E	xeminer: On the basis and manner	s of examination stated.	ation and/or in	vestigation, in my o	pinion, dea	th occur	ed at the time,	date and plac	e, and due	to the cause(s)	
	To tha within 2 To tha complet	Σ	29b. Signature an	d title of certifier				29c. Licens	e number			29d. Date sig	ned (Month,	Day, Year)	
	1			M	MA			03	895	5		1/15	12004		
	15		30. Name and add	tress of person v	vho completed cause	death (Ite	m 23a) (Type,	Print)		1	1 .4	/	1 1	MDZIII3	
	1		Dalies	et du	Agh Siell	u l	413 1	napple	1 1	vay	#10	6 000	ento	n MD XIII3	
	Sta	te	31. Date filed (Mo	nth, Day, Year)	1004 32. Reg	strar's Sign	SINLO COL								

			For State Registrar	tate of Maryland /		tment of H			giene 200	4 00854
			Decedent's Name (First, Middle, Last)					2. Date of Dea	ath Day Ye	3. Time of Death
	Physicia /Medic	_	Clifford E. Bei					Janvan		
>	Examin	er	4a. Facility Name (If not institution, give street		4	4b. City, Town, or	0		4c. County of D	eath
			JOHNSHOPKINS BAYUI	7. Age (In yrs. last		TER If Under 1 Year	If Under 24 Hrs.	MORE 8. Date of Birt		Birthplace (State or Foreign
	Funeral Director			2□F 85		Months Days	Hours Min.	8. Date of Birt (Month, Day 52pt. 7	y. Year) 1918 1	Country)
	D		Usual Residence of Decedent							
	show	_	Maryland Baltimor	10c. City, To	own or Loca	1 4				10d. Inside City Limits 1. Yes 2 □ No
	8a-f	Director	1121 12.00		Dort				10g. Citizen of What	
	th with t	al Dir	10e. Street and Number	oth Street		10f. Zip Code 2122	?4		Daited	States
036	should be filed within 72 hours after death with the Maryland to Mental Hygiene. marked other than "natural", or ltems 23e or 28e-f show matic event, the Medical Exameter must be notified at	by Funeral		Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 No If Yes, Give Year or Dates:		as Decedent of Hi res, specify Cubar Yes 2 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, White, etc.
2	72 ho	eted	15. Decedent's Education (Specify only highest grade co	on 16	6a. Deceder	nt's Usual Occupa nd of work done d	tion uring most of worl	kina	16b. Kind of Busine	ess/Industry
21	filed within 72 Hygiene. other than *nal	Completed		College (1-4or 5+)	life. DC	NOT use retired)		9	Produ	CP.
2	lled w dygie ther ti		17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First Middle	Maiden Sumame)	
land	should be filed with tind Mental Hygiene s marked other that umatic event, The I	To Be	John L. Beye	~			Grac	- 4	iomas	
Maryland 21215-0036	W = m =		19a. Informant's Name/Relationship (Type,		-	Address (Street a		1.1	or, City or Town, State	e, Zip Code) 4
	Health Health tem 27		20a. Method of Disposition	20b. Place	of Disposit	ion (Name of		Date 17	20c. Location - City	or Town, State
altimore,	Pages ment of ant: If it		1 M Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	SACY E	al Hear		\$ 2	004	Dundalk,	Maryland
Balt	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra once.		21. Signal are of Funeral Service Licensee			Vame and Addres		Home of Rd. Du	Dundale, MD	P.A. E1222
			23a. Part1. Enter the disease, or complicati shock, or heart failure. List only one c	ons that caused the death. Dause on each line.	o not enter	the mode of dying	, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
	Physician	ì	Immediate Cause (Final disease or condition	Congestive	He	aft Fa	lore			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a) a consequence	114171					
		7	Sequentially list conditions, b. —	Due to (or as a socisequence	ce of):	y alse	ise_			
7	uted ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	` '	,					
oʻ	exect an and rial-tra	Exa	resulting in death) Last	Due to (or as a consequent	ce of):					
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dlcal	d							
9	ertific ding p	Med	IF FEMALE:	If you buttooms of programme						
Вох	that the death certificed by the attending properties as	by Physician/Me	in the past 12 months?	If yes, outcome of pregnancy 1□Live birth 2□Fetal dea 4□Pregnant at time of death	ath 3⊟E	ctopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
<u>Р</u> О	y the	nysk		9 Unknown		other (apoony)				
	signed b	y Pt	Part II. Other significant conditions contrib	uting to death but not resultin	g in the und	erlying cause give	n in Part I.	23e. Did to	bacco use contribut	e to the cause of death?
ğ	w require been sig should b							1 🗆 Y	′es 2 No 3 □	Probably 4 Unknown
ဝ၁	law requas been 2 should	Completed						24a. Was autop	an 24b. Were	autopsy findings available to completion of cause of
Ž.	The ate ha	Com						perfo	rmed? death	
/iita	cian: ertific ector,	Be	25. Was case referred to medical examiner?	unal.		0.1	26. Place of Dea	th (Check only o	ne)	
5	Physi this c	7 2	1 Yes 28 No Hosp	1 patient 2 EH/	Outpatient b. Time of	3 DOA Other	4 Nursing Fi		dence 6 Other (5	Specify)
Division of Vital Records,	ding I h. After funer	tlon	1 Natural 5 Pending	28d. Describe r	now injury occurred					
/ISI	Atten r deat octor: by the	fica	3 Suicide 6 Could not be	28f. Location (S	Street and Number of	Rural Route Number,				
á	s after al Dire	Certification:	4 Homicide	building, etc. (Specify)				City or Tow	m, State)	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical		an: To the best of my knowled On the basis of examination and manner stated.						
	Fo the Within Fo the	Me	29b. Signature and title of certifier	A.		29c. License	number		29d. Date signed (M	onth, Day, Year)
	/		Yanna & L	and mr		RES	000		Januar	15. 2004
	1	}	30. Name and address of person who come Hopkins Bayview Me	leted ause of death (Item 23	a) (Type, Pr	int) Lauva	Hannok	mo	, and	
			Hopkins Bayview Me	dical Center	49	40 East	tern Au	e, Bal	timore, M	D 21224
	Sta Registr		31. Date filed (Month, Day, Year) JAN 1 6 2004	32 Registrar's Signature						
Sec.	100		PURIS I I STATE	M. W. Marker a She	of material a	All A				

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene)

For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** January 8, 2004 Margaret S. Bambrick /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOVE OF CROCE

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. | Apr 3, 1915 Har-NURSING TORD itizeno Home 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2 🛛 F 88 Yrs. Virginia 226-24-5639 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be nutified at once. 1 ☐ Yes 2√ No Havre de Grace Director MD Harford 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21078 415 S. Market Street USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: white Be Completed by 3 ☐ Widowed 4 🖾 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) elementary teacher education 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Catherine Wine George Emery Sheets Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary Lynn Snyder/daughter 615 Commerce Street Havre de Grace, MD 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 Donation 5 ☐ Other (Specify) State Anatomy Board 655 W. Baltimore Street 21. Signature of Euneral Struice Licensee Kona d S Waden Baltimore, MD 21201 mun Approximate Interval Between Onset and Death nt. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ok, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Sebsis daye **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Certification: To Be Completed by Physician/Medical cate has been signed by the attending page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Brunchitis 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an certificate has Hypothymod 1 Yes 2 No Hospitel or Attending Physicien: nerel Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MIRZA A BAIG MID D43115 1-8-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , Havre de Grace, MD, 21078 Union Ave 5 -3. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 1 6 2004 Registrar

DHMH 17 Rev 1/2001

Bambriele, Margaret 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year Physician anuary 1601 M 2004 /Medical 4c. County of Death 4a. Facility Name (If hot institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 24 Hrs. If Under 1 Year Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 10 M 2□ F Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State the Medical Examinant mat be notified at 1 ☐ Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Items 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🗵 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any injury or other traumatic avant, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Wayne 19a. Informant's Na e/Relationshi (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Important: any injury o once. ' 4 ☐ Donation 5 ☐ Other (Specify) Como. 21. Signature of Funeral Service Ucensee 22. Name and Address of Facility EVQ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death OBSTRUCTIVE PRELYONARY Immediate Cause (Final disease or condition resulting in death) SEVERB Pnysician 6ND) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Internating decorption, page 2 should be detached for use as the burial-transit INTESTINIAL Due to (or as a consequence of) Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Dav 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2□ No 1 ☐ Yes 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes 28a. ate of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 🗌 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

ANUSHA-SIRIMARA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOD

7505

Pegistral's Signature

29d. Date signed (Month, Day, Year)

OSIGR DRIVE, TOWSON

		1 - For State Registrar Unpend Item#	State of Maryland 23a,27,Per ME,C829				ene 2001	008
Physici	an	Decedent's Name (First, Middle, La		\cap		2. Date of Death Month	Day Yeer	3. Time of Dea
/Medic		PATRICK	SHAMAR	COA	TESON		13, 2004	10:20
Examin	er	4a. Fecility Name (If not institution, giv	re street and number)		ity, Town, or Location of D	eath	4c. County of Deat	h
		3806 Bonner Road 5. Social Security Number 6.5	Sex 7. Age (In yrs. I		Baltimore derlYear fUnder24	dre la Data at Diat	N/A	
Funeral Director			1 M 2□F	Yrs. Mont		frs. 8. Date of Birth (Month, Day, Y	ear) 9.81n 2001 M	hplece (State or Fountry) ARYLAA
Maryland -f show lind at		10a. State 10b. County	10c. City	, Town or Location		0		10d. Inside City Li
	Director	MARYLAND 10e. Street and Number)/A	B	ALTIMOR	ECITY		1/1 Yes 2
E 0 8	al Dir	3806 BON	INER ROAL	5	Zip Code	2/6	. Citizen of What Co	4.
sms 23	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. Was De	cedent of Hispanic Origin?	(Specify Yes or No-	14. Race - Ame Bleck, White	
naturel', or ita	by	1 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		s 2 🖄 No Specify:	,	Specify: 3	ACI
c * #	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Decedent's U	Isual Occupation work done during most of T use retired)	working 16	b. Kind of Business/	Industry
then.	mc	Elementary/Secondary (0-12)	College (1-4or 5+)	III DO NO	() / n		A1/	A
ovent, It a		17. Father's Name (First, Middle, Last,)		18. Mother's	Name (First, Middle, Ma	iden Sumame)	<i>A</i>
marked other then marked other then matic event, It a M	To Be	DWAVNE S.	HAMAR C	ATESO	,	ai REI	UEF A	OPSEL
and N		19a. Informant's ame/Relationship (ess (Street and Number or	Rural Route Number, C	ity or Town, State, 2	ip Code)
Health and Meritam 27 Is market other traumatic		MONICA COX	(GRANDMOTHER)	1841	LOCH SI	HIEL RD, X	BALTO, 1	40.215
	. 8	20a. Method of Disposition	20b. Pl	ace of Disposition (/	Vame of	The state of	c. Location - City or	Town, State
nent ment mury o		1 Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specific	Jhemovai mom State	DLAWN	CEMETERY 01	-19-04 4	10001 AIN	1) M1
Departmen Important: any injury		21. Signature of Funeral Service Licer		22. Name	and Address of acility	Benne	R FUNE	RAI Hai
20 = 2			1100	393	PON FULT	ON AVE L	BAITO, M	0.212
Medical Asician and he burial transit	al Examiner	Sequentially list conditions, if any leading to immodate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence. Due to (or as a consequence.	ence of): ance of):				
e attending pl	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnan 1 Live birth 2 Fetal of the Pregnant at time of decompositions of the second seco	death 3 □Ectopic			23d. Date of delin	very Day Year
should be detache	by	Part II. Other significant conditions o	ontributing to death but not resul		Did tobacco use contribute to the cause of death 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unkn			
hould	eted					- 1 Yes	2 No 3 Pro	babiy 4 T Unkr
ate has page 2	Completed					24a. Was an autopsy performed	prior to co	opsy findings avai empletion of cause 2 No
this certific	Be	25. Was case referred to medical examiner?	Hanadali			eath (Check only one)		
0 0	၉	1 X Yes 2 □ No 27. Manner of Death	Hospital: 1 Inpatient 2 E	Home 5 Residence	ome 5 Residence 6 Nother (Specify) at SCC			
ath. r: After e funer	atlon	1 ■Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28d. Describe how i	28d. Describe how injury occurred28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined						28f. Location (Street City or Town, St
s after de al Directo ad in by th	Cert		ce, and due to the cause	due to the cause(s) and manner as stated. It the time, date and place, and due to the cause(s)				
s 24 hours after de Funeral Directo letely filled in by th		29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my know niner: On the basis of examination and manner stated.	on and/or investigation	on, in my opinion, death oc	curred at the time, date	and place, and due t	o the cause(s)
within 24 hours after de To the Funeral Directo	edical	29a. Certifier (Check only one) 1 ☐ Certifying Ph 2 ☐ Medical Exam 29b. Signature and title of certifier	niner: On the basis of examination	on and/or investigation	on, in my opinion, death oc		and place, and due t Date signed (Month,	o the cause(s)
Funer Funer Felly fill	edical	one) A Medical Exam	niner: On the basis of examination	on and/or investigation		` 29d.		Day, Year)
To the negpties of Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Medical	one) A Medical Exam	and manner stated.	on and/or investigati	9c. License number	` 29d.	Date signed (Month,	Day, Year)

			For State Registrar		Maryland / D	Departmer		and Mental		2001.	00859	
			1. Decedent's Name (First, Middle, Las	t)	2. Data	of Death h Day	Yaar ,	3. Time of Death				
	Physicia /Medic		Cecil R. Ch	ambers,	Jr.			San(ian; lo		835 A M	
14	Examin		4a. Facility Name (If not institution, giva	4 11	"	4h City,	Town, or Location		4c.	County of Death		
	· · · · · · · · · · · · · · · · · · ·		Maryland Genra		ospital	Taraba Millada	Himore		-4 Dist	N/A		
	Funeral Director		5. Social Security Number 6. Sec. 214-44-2168	X XM 2□F	Age (In yrs. last bir 56	Yrs. Months		Min. (Mon	of Birth	_	place (State or Foraign ntry)	
	-		Usual Rasidence of Decedent		56			Aug	8,194	/ Mary	yland	
1	Maryland -f show fied at		10a. State 10b. County		10c. City, Tow					1	0d. Inside City Limits	
7	ith the Marylas or 28e-f show the notified at	cto	M.D. N/A		Balti	more					Yas 2 No	
9	vith th	Dire	10e. Street and Number	C.L		10f. Zip				zen of What Cour	try?	
Robe,	1 234	Funeral Director	827 N. Charles		at Ever in II S	12 Was Door	21201	Visin? (Specify Vos		U.S.A.	en Indian	
2	fter d	Fun	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces	? 10/31/	68 If Yes, spe		origin? (Specify Yes an, Puarto Rican, et		Black, Whita,	atc.	
2036	ours aft	by	3 ☐ Widowed 4 ☑ Divorced	If Yes, Giva Year or Dates	-6/17/6	9 1□ Yas	2 XNo Specif	y:		Specify: Bla	ıck	
20-	72 ho	Completed	15. Decedant's Ed (Specify only highest grad	ucation de complated)	16a.	Decedant's Usu (Giva kind of wo	al Occupation ork dona during mo sa ratired)	ost of working	16b. Kii	nd of Businass/Inc	dustry	
.2 <u>≥</u>	dithin hen.	mpl	Elamantary/Secondary (0-12)	Collega (1-4o	r 5+)		permitted and the second		a 1	C = 1		
200	lied w lygies ther ti		10th 17. Fathar's Nama (First, Middle, Last)			Entre	prnuer	har's Nama (First, M		f Emplo	yed	
and	antal h) Be	Cecil R. Chambe	rs. Sr.				ssie Car		Sumame		
<u>-</u>	should mark matic	2	19a. Informant's Name/Relationship (7		her 19b	. Mailing Addrass	-	ber or Rural Route M		r Town, State, Zip	Coda)	
S BM	s 1 and 2 should be filed within 72 hours after death with the Maryla f Heelth end Mental Hyglene. Item 27 is marked other than "netural", or items 23e or 28e-f shot other treumatic event, the Medical Extendings must be notified at		Cecil R. Chambe			111000						
e, e	of Hee		20a. Method of Disposition		cometer	Disposition (Na.	me of other place)	Date	20c, Lo	cation - City or To	M. D. 21201 own, Stata	
altimore, M	Page nent c int: If iry or		1 ☐Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		° Garri	son Fo	rest	1/20/200	04 Owi	ngs Mil	lls, M.D.	
	permit. Pages Department of I Importent: If Its eny injury or o		21. Signatura of Funeral Service Licen	P3 11-	11	22. Nama ar	nd Addrass of Fac	ilityNutter	Funer	al Home	inc.	
3	20 = 2 9		Illed	c. Nu	ller			alls Pkv		to.,M.	21216	
			23a. Part1. Entar tha disaasa, or comp shock, or haart failura. List only o Immediata Causa (Final	A .		not antar the mod	le of dying, such a	s cardiac or raspirat	ory arrast,		Approximate Interval Batwean Onsat and Daath	
	Physician / /Medical	1	disaase or condition rasulting in daath)	a	osclero	HIC CC	urdio v	asciela	r Dis	sease		
	Examiner			Dua to (or a	is a consequance	or):						
		Jer	Sequantially list conditions, if any, laading to immediata causa. Entar Undarlying Cause (Disaase or injury	Due to (or a	s a consequence	of):						
	be executed icien and burial-transi	Examiner	that initiated events	с								
760,	te be exe ysicien a ne burial-		rasulting in daath) Last	Dua to (or a	is a consequence	of):						
87	0 % 0	dical		d								
× 6	ding se as	/Me	IF FEMALE:	23c. If yas, outcom	e of pregnancy					3d. Data of delive	nn/	
B	atter 1 for u	clar	23b. Was decedent pregnant in the past 12 months?	1 Liva birth	2 Fetal death at time of death	3 ☐ Ectopic po 5 ☐ Othar (se					Day Year	
o.	by the achec	hys	9 Unknown	9□ Unknown								
Division of Vital Records, P.O. Box 68	Attanding Physician: The law requires that the death certificate or death. scioc: After this certificate has been signed by the attending phys the funeral director, page 2 should be detached for use as the	by Physiclan/Med	Part II. Other significant conditions co	entributing to death	but not resulting in	the underlying o	ause given in Part	23e.	Did tobacco u	se contribute to th	e cause of death?	
pro	equire	ted							1 ☐ Yes 2 ☐	□No 3 □ Prob	ably 4 Denknown	
e c	e law r has be je 2 sh	Completed						24a.	Was an autopsy	24b. Were autop	osy findings available inpletion of cause of	
<u> </u>	The cate h	Con						101	performed? res 2 PNo	death? 1 ☐ Yes		
Zit Zit	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Other	ce of Death (Check		***		
o to	Phys r this ral di	. T	1 Inpatiant 2 Let R/Outpatient 3 DOA 4 Nursing Home 5 Rasidence 6 Othar (Specify)									
o	ding It.	tlor	1 Natural 5 Pending 2 Accidant investigation		Jay Yaar) li	njury M	28c. Injury at Work? 1 ☐ Yes 2 ☐					
N. S.	Attendi	Ifica	3 ☐ Suicide 6 ☐ Could not be datarmined	28a. Place of II	njury - At home, fa	rm, street, factor	y, office	28f. Local	ion (Straet and	Numbar or Rura	Routa Number,	
ā	tal or	Cert	4 Nonicida	building, a	atc. (Specify)			City	or Town, Stata)			
1	To the Nospitel or Attending Physicien: The lawithin 24 burs after death. To the Funeral Director After this certificate has completely filled in by the funeral director, page 2	Medical Certification;	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	vsician: To the bes iner: On the basis and manner s	of examination and	, death occurred d/or investigation	at the time, date a , in my opinion, de	and place, and due to eath occurred at the	the cause(s) time, date and	and manner as sti place, and due to	ated. the cause(s)	
	Within To L	Σ	29b. Signature and title of certifier			29	. License number		29d. Date	signed (Month, L	lay, Year)	
	24						3950	4	1/1	0/04		
	1		30. Nama and address of person who	ted cause of	death (Item 23a) (20	10:10	. 1 2	enera	1 1-ta	00: 401	
	Sta	te	31. Data filed (Month, Day, Year)	32. Regis	trar's Signatura	1110	in la	La G	cial u	1 1 10	ا ٢٠ الراد	
	Registr	-	JAN 1620	04	the state of the	Argan Mil						

DHMH 17 Rav 1/2001

ORIGINAL

4-0022 KG					f Maryland / D 28a-f per u				_	1. 000cc			
9					28a-1 per u	Pertificate 6	71 Cathtas	Re	J. No.	4 00000			
Phys	sician	Decedent's Name (First)	_		Date of Death Month	Day Yea	3. Time of Death						
/Me	edical	Kichard				1 41 01 7		Januar					
Exa	miner				•	4b. City, Town	n, or Location of Dear	th	4c. County of De	eath			
Fune	rol	15521 Old F 5. Social Security Number	reder 6.5		1 7. Age (In yrs. last birth	Emmits		8. Date of Birth	Frederi	Ck Birthplace (State or Foreign			
Direct		219-32-4072 Usual Residence of Deced	1	MM 2□F	69 Y	Months Day	ys Hours Min		ear/	country) ryland			
ylanc		10a. State 10b. County 10c. City, Town or Location											
Ma a-f-e	cto	MD F	reder	ick	Emmi	tsburg				1 ☐ Yes 2¶ No			
be filed within 72 hours after death with the Maryland tall hygiene. atal hygiene. and other then "natural", or Itams 23a or 28a-1 ehow svent, the Medical Exprine must be notified as	Director	10e. Street and Number				10f. Zip Code	9	100	g. Citizen of What	Country?			
ath w	187	15521 01d	Frede	rick Roa	ıd		21727		UŜA				
ar de tams	Funeral	11. Marital Status		Armed For	dent Ever in U.S.	 Was Decedent of If Yes, specify Co 	of Hispanic Origin? (Suban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ar Black, WI	merican Indian,			
safte or i	L			1 ☐ Yes 2 X No If Yes, Give		1□Yes 2XIN			Specify: W				
hour tural	Completed by	3 Widowed 4 Di	cedent's E	Year or Da		academia i laval Oca							
of within 72 hours aft giene. er then "natural", or	lete	(Specify only	highest gra	ide completed) (Give I		ecedent's Usual Occ Sive kind of work don fe. DO NOT use reti	ne during most of wo	rking	8b. Kind of Busines	ss/Industry unk			
within lene.	l la	Elementary/Secondary (Elementary/Secondary (0-12) College (1-4or 5+)				700)						
Hygie att.	Ŭ		liddle, Last,			laborer	18. Mother's Na	me (First, Middle, Ma	o (First, Middle, Maiden Sumame)				
		Victor	Chri	.st				Marie Beme					
d 2 should be in and Mental if and Mental if 7 is marked of traumatic sve	-	19a. Informant's Name/Re	ationship (Type, Print)	19b. N	lailing Address (Stre			oute Number, City or Town, State, Zip Code) un				
		Anthony Koha	jda/u	nc1e					,	all distance and the second			
is 1 and 3 Health Item 27 other fr		20a. Method of Disposition			20b. Place of D	sposition (Name of	(Date 20	c. Location - City o	or Town, State			
Pages nent of int: if it		1 ☐ Burial 2 ☐ Crem 14 ☐ Donation 5 ☒ O			State	crematory or other p	1						
	6	21. Signatur Funeral S											
permit. Departrimports	Suce	Mana	1/1	Ward J. D	irector	State Ana Baltimore	tress of Facility tomy Boar MD 212	d 655 W. I	Baltimore	Street			
\$ 1	12	23a Pan 1. Enter the dise	ise, or com	plications that ca	used the death. Do not					Approximate			
Physicia		shook, or heart failure Immediate Cause (Final	. List only	one cause on ea	ich line.					Interval Between			
/Medic		disease or condition resulting in death)	-		ermia Complor as a consequence of)	icating A	tneroscle	rotic Caro	liovascul	ar Disease			
Examin	er												
τ,	je je	Sequentially list conditions if any, leading to immediat cause. Enter Underlying	,	Due to (or as a consequence of)	as a consequence of):							
cuted id ansit	Examiner	Cause (Disease or injury that initiated events	1	c									
te be executed ysician and e burial-transit			resulting in death) Last Due to (or as a consequence of):										
- -		d											
death certificate attending phy do for use as the	Physician/Med												
attending for use	N/CE	IF FEMALE: 23b. Was decedent pregna			come of pregnancy	3 □Estania arassas			23d. Date of d	elivery			
. 0 0 0	Sicia	in the past 12 months 1 ☐ Yes 2 ☐ No	?	1 Live birth 2					Month Day Year				
that the ded by the	hy	9 Unknown		9LJ UNKNO	wn								
o, r res tha igned be del	by		nditions c	s contributing to death but not resulting in the underlying cause given in Part I.				23e. Did tobac	cco use contribute to the cause of death?				
w requires been sign should be								1 🗆 Yes	2 □ No 3 □ F	robably 4 Unknown			
2 st	ompleted							24a. Was an	24b. Were a	autopsy findings available			
The I	E O							autopsy performe 1 Yes 2	d? death?	completion of cause of			
ician: Th certificate rector, pag	9	25. Was case referred to n	edical				26. Place of Dea	ith (Check only one)	No 1 (A Ye	s 2□No			
Physician: r this certific ral director,	ToB			Hospital: 1 ☐ In	patient 2 ER/Outpa	tient 3 DOA	the man	ome 5 Residence	e Switcher (Sp.	ecify)			
				28a. Date o	Injury 28b. Tim	e of 28c. Ing	ury at	28d. Describe how	injury occurred				
or Attending after death. Director: After	atic	1 □Natural 5 □ 1 2 🔀 Accident	ending nvestigation	1,200		Ö P M 10		railer	posea 10	Cold In A			
or Attend after death Director:	tific	3 ☐ Suicide 6 ☐ 6	Could not be letermined	286. Place	of Injury - At home, farm g, etc. (Specify)	street, factory, office	9	28f. Location (Stree	t and Number of P	Old Frederi			
rs after al Dir	Certification:			Reside				oad, Emmi	tsburg, I	Md.			
To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	edical		rtifying Ph dical Exam	ysician: To the la niner: On the ba- and mann	pest of my knowledge, d sis of examination and/o	eath occurred at the rinvestigation, in my	time, date and place opinion, death occu	, and due to the caus	e(s) and manner a and place, and du	s stated. e to the cause(s)			
To the within 2 To the comple	Me	29b. Signature and title of		and mailli	J. 3.9100.		nse number		Date signed (Mon				
F ≥ F 8		> high		MiD				230.	- and digited (MOI)	, 50,, 1021)			
		1			of death fire— as . =		.M.E.	J	anuary 2	, 2004			
		30. Name and address of p			ा वर death (Item 23a) (Ty								
R L Call	State	31. Date filed (Month, Day,			gistrar's Signature	111 Per	on Street,	Baltimor	e, Maryla	and 21201			
	strar	•	6 200	Pl.	_	rantes							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Dorothy 14, 2004 01:30 AM Darlene Dixon January /Medical 4a. Facility Name (If nor institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore University of Maryland Medical Center 5. Social Security Number If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 T F 220-40-0972 61 Director Usual Residence of Decedent Maryland 10a State 10c. City, Town or Location Sykesville 10b. County if te marked other than "natural", or Itema 23a or 28a-f ahow traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits MdCarroll Director 1 Yes 2 No the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Schneider Drive 21784 "natural", or Itema 23a USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ YO If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 274s marked other than "natural", or Iten any injury or other thaumatic event, the Medical Evarina Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Tes 2 No 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) health care registered nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lawrence Glover Blanche Schlossnagle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1 Schneider Dr., Sykesville, Md 21784 Mr.Uscar Dixon Jr. (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Wurial 2 Cremation 13 Removal from State
4 Donation 5 Other (Specify) Lake View Memorial 1-18-04 Sykesville, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Blan & P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** metastatic breast cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, harry, loading to minimize cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical 88 IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) ate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 2 🐼 No 1 🗌 Yes Be Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 1 Yes 2 1 No 2 🖸 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 1 ☑Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pendina hours after death. uneral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral [the Hospital Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P16551 14, 2004 January 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Greene St. 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

			= State Amend Item 3 p	State of Ma er Dr.,G829	aryland ,03/08/0	/ Depa //dab	artment of H tificate of	lealth and <i>Death</i>	Mental Hy	giene , Reg. No.	2004	00862
	<u> </u>		1. Decedent's Name (First, Middle, Las	•		1 -			2. Date of De Month	ath Day	Year	3. Time-of Deatham
	Physicia /Medic		HUNNUH	EE (DUB	0 50			JUNAN		4 200	A Dog to
	Examin		4a. Facility Name (If not institution, give	street and number)		- D	4b. City, Town, o	r Location of Dea	ath c		ounty of Death	1
			5. Social Security Number 6. So	1700	100	-5	If Under 1 Year	Tif Under 24 Hi	s. 8. Date of Bir		I/A	place (State or Foreign
	Funeral Director	1			9 (In yrs. las. 89	Yrs.	Months Days	Hours Mir		y, Year) 191	5 Con	intry) C
			Usual Residence of Decedent						bair.	1101	5 5	
	yland		10a. State 10b. County		10c. City, 7	Town or Lo	cation					10d. Inside City Limits
	a-f s	ctor	MD N/	A	E	Balti	more					1X Yes 2 □ No
	ter death with the Marylan Items 23s or 28s-f show Items to notified at	Director	10e. Street and Number				10f. Zip Code			10g. Citize	n of What Co	intry?
	ath w	ral	2434 Terra Fir				212				U.S.A	\•
	er de	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13. \	Was Decedent of I f Yes, specify Cub	tispanic Origin? (an, Mexican, Pue	Specify Yes or No rto Rican, etc.)	- 14	Black, White	
36	ੂਰ ਗ੍ਰ	by F	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ♣ N If Yes, Give Year or Dates:	40		I□Yes 2⊠ No	Specify:		s	ipecify: B1	ack
Ö	n 72 hours "naturel", edical Ext		15. Decedent's Ed	ucation	-	16a. Deced	ient's Usual Occup	pation		16b. King		lothing
215		ple	(Specify only highest gra	de completed) College (1-4or 5	i+)	(Give life. i	kind of work done OO NOT use retire	during most of w d)			facto	
21		Completed	12th	30 (1)		eams	tress					
Maryland 21215-0036	be filed that Hygie of other the other than the oth	Be (17. Father's Name (First, Middle, Last)						ame (First, Middle,			
yla	should be ind Mental in marked umatic ev	ဥ	Jack B. Spann						a Richa			
Jar	2 short and and le m		19a. Informant's Name/Relationship (7						Rural Route Numb			
	s 1 and 2 should I Health and Mer Item 27 is marke other treumatic		Margaret C. Sm	rtn-baug			NOTTING	Jnam Ka	. Apt.3		Ito., ation - City or 1	
و	6 O		1 ☑ Burial 2 ☐ Cremation 3 ☐		cem	etery, cren	natory or other pla 11 Cem.		0/04 A		•	el Co., MD
Baltimore,	it. Partmen		*4 □Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		Joean							
Ba	permit. Pag Department Important: t eny injury o		Dranfor Mel	w-		25	01 Gwyr	ns Fal	ls Pkwy	. Ba	al Hor lto.,	
н			23a. Part1. Enter the disease, or companies shock, or heart failure. List only	olications that caused one cause on each lir	the death.				ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. 1/ent	1cula-	17	brillaho	7.1				
	/Medical Examiner		resulting in dealiny	Due to (or as	a consequer	nce of):	DI	1.				8
		er	Sequentially list conditions,	b. Due to (or as	a consequer	nce of): -	th race	1100				O MIMANES
	nsit	ulu.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	14	20- H	n5/01						8 minutes 20 ears
Ć,	n and ial-tra	Examin	that initiated events resulting in death) Last	Due to (or as								
8760,	death certificate be executed e attending physician and od for use as the burial-transit	dlcai	(d							-	
9	tifical ng phy as th	led										
Вох	ath certific ttending p or use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 Live birth			Ectopic pregnanc	y		23	d. Date of delin	
	the atte	sicl	in the past 12 months? 1 Yes 2 No	4☐ Pregnant at 9☐ Unknown			Other (specify)	·			MOHIN	Day Year
P.0	that the d ad by the detached	Phy	9 ☐ Unknown Part II. Other significant conditions c	natabuting to death h	ut not roculti	na in tha u	adorhina causa an	on in Part I	23e Did t	obacco use	contribute to	the cause of death?
ds,	es pu	d by	Fall II. Other significant conditions o	onthodang to death b	at not results	ing in the di	identying cause gi	on in raiti.	1 🗆 '			bably 4 Unknown
of Vital Records,	w requir been s should	ompleted							24a. Was	20	24h Ware au	oney findings available
Rec	e las has	d w							autor	rmed?	death?	opsy findings available ompletion of cause of
a	ician: Th certificate rector, pag	e Co	25. Was case referred to medical					26 Place of D	1 ☐ Yes eath (Check only o	2 X No	1 🗆 Yes	2) 21 No
Ξ	Physician: this certific ral director,	o B	examiner?	Hospital: 1 ☐ Inpatie	nt 3 EP	VOutpatien	t 3 DOA Ott	oc.	Home 5 ☐ Resi		Other (Spec	ifu)
	g Phy erthi	n:T	27. Manner of Death	28a. Date of Injur (Month, Da)	-	3b. Time of		y at	28d. Describe			.97
ion	Attending ir death. ector: After by the fune	atlo	1 XiNatural 5 ☐ Pending 2 ☐ Accident investigation		y (621)	injury		Yes 2 □ No				
Division	or Attending Fiter death. irector: After n by the funera	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju-	ury - At home c. (Specify)	e, farm, str	eet, factory, office		28f. Location (. City or Tox		Number or Ru	ral Route Number,
Ö	itel or A								1			
4	To the Hospitel of within 24 hours at To the Funeral Completely filled in	edical		ysician: To the best on the basis of and manner sta	examination							
	To th To th comp	Me	29b. Signature and title of certifier	1	/		29c. Licen:			-	signed (Month	
,	1		16 Cull /n	nounne	h N	10	D 00	5202	2	Janu	ary/	1, 2004
	V		30. Name and address of person who	completed cause of d	eath (Item 2	3a) (Type,	Print)					
徵	Sta Registi		31. Date filed (Month, Day, Year) JAN 1 6 2004	32. Registra	ar's Signatur	o walls						

	500		1 - For State Registrar	State o	f Marylan	nd / Depa	artment of	f Health a of Death	and Me		ene 2	004	0086	0
	Physici	an	Decedent's Name (First, Middle,	, Last)						. Date of Death Month	Day	Yeer	3. Time of Death	
	/Media	cal	Maria		A .		I	Dixon		anuary		2004	1355 M	_
	Examir	ner	4a. Facility Name (If not institution, 2260 Mist Have		mber)			n, or Location				y of Deeth		
				6. Sex	7. Age (In yrs.	last hirthday)	Gam I	brills ear If Under		. Date of Birth	Anne			_
	Funeral Director		214-52-7556	1□M 2∏F	72	Yrs.	Months Da		Min.	(Month, Day, leb. 5,			elace (Stete or Foreign etry)	,
			Usuel Residence of Decedent						I	eu. J,	1931	Ger	many	_
	yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					1	0d. Inside City Limits	
	a-f.s	ctor	MD Anne	Arundel	G a	ambril	l1s						1 Tes 2 No	
	or 28	Oire	10e. Street and Number				10f. Zip Cod	е		10	g. Citizen of	What Cour	itry?	
	23a	rail	2260 Mist Haver	n Lane				1054			USA			
	tems tems	Funeral Director	11. Marital Status	Armed Fo	edent Ever in U rces?	.S. 13.	Was Decedent of If Yes, specify C	of Hispanic Ori Juban, Mexicar	igin? (Specit n, Puerto Ric	fy Yes or No- can, etc.)		ce - Americack, White,		
2	s afte	by F	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 Tes If Yes, Giv Year or D	/8		1 □ Yes 2	No Specify:	:		Speci	y: Whi	te	
3	filed within 72 hours after death with the Maryland Hygiene. In the than "natural", or Items 23a or 28a-f show on, the Macical Examiner must be mortified at		15. Decedent		4165.	16a Dece	dent's Usuat Oc	cupation		11	6b. Kind of E	Business/lea	tuctor	
2	in 72	Completed	(Specify only highest	grade completed)		(Give	kind of work do DO NOT use re	ne durina mos	st of working	' '	db. Killd bi E	ousiness/in	dustry	
7	l with jiene.	E O	Elementary/Secondary (0-12)	College (1	1-4015+)	Home	maker				Own	Home		
2	othe	a l	17. Father's Name (First, Middle, L	ast)				18. Mothe	er's Name (F	First, Middle, M	aiden Sumai	me)		_
<u> </u>	uld be Aental rked o tic eve	To B	Mathias Girner					Mar	ia Fab	lemyer				
2	2 should be filed within and Mental Hygiene. Is marked other than surmatic event, the M.		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailir	ng Address (Stre	eet and Numbe	er or Rural F	Route Number,	City or Town	, State, Zip	Code)	
2	ges 1 and 2 should be filed within 72 hours after death with the Maryla It of Health and Mental Hygiene. If item 27 is marked other than "netural", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be multipled at		Deward M. Dixor	n (Husban	d)	2260	Mist H	aven La	ane, G	Gambrill	ls, MD	2105	4	
ט 5	of He		20a. Method of Disposition 1 XBurial 2 Cremation	3 □Removal from	State	emetery, crer	sition (Name of natory or other)	place)	Date	-	0c. Location	_		
	Pages ment of t ant: If it ury or of		'4 □Donation 5 □Other (Sp		M D	Veter	ans C	em. 1	L - 16 -	04 C	rowns	svill	e,MD	
Ē	permit. Pages 1 and 2 Department of Health s Important: If item 27 is eny injury or other tra once.		21. Signatura of Funeral Service L	ioensee		22	.Name and Ad Lardes	dress of Facility Fun	iy iera1	Home	PARns	poli	agely av	FE
	Physician Medical Examiner The privateansit private from the private from	dicai Examiner	23a. Part1. Enter the disease, shock, or heart failure. Let of the shock of the sho	b. — Due to (ach line.	uence of):	er the mode of a		111-12				Approximate Intervat Between Onset and Death	
.c. box 06	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₩ No 9 □ Unknown	1 Live b	come of pregna pointh 2 Feta ant at time of d	Ideath 3□	Ectopic pregna Other (specify,					ate of delive	ry Day Year	
- (22)	quires than signed I	by	Part II. Other significant condition	ns contributing to de	eath but not res	ulting in the ur	nderlying cause	given in Part I.			_		e cause of death?	
	rsician: The law requir s certificate has been si director, page 2 should I	Completed								24a. Was an autopsy perform	ed?	prior to con death?	psy findings available appletion of cause of	Ī
3	an:] tifical tor. p	0	25. Was case referred to medical					26. Place	a of Death (C	1 Yes 2 Check only one		1 🗆 Yes	2□ No	_
	ysici is cer direc	To B	examiner? 1 X Yes 2 □ No	Hospital: 1 🔲 I	npatient 2 🗌	ER/Outpatien	t 3 DOA			5 Residen		er (Specify)	
5	ith. : After this e funeral di		27. Manner of Death 1 SNatural 5 Pending 2 Accident investigation		of Injury th, Day Yeer)	28b. Time of Injury	28c. Ir V	njuryat Vork? ☐ Yes 2 ☐	280	d. Describe how			,	
2	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	and 288. Place	of Injury - At ho ng, etc. (Specif	ome, farm, stre	eet, factory, office	СӨ	28f	. Location (Stre City or Town,	et and Numi State)	per or Rural	Route Number,	
	Hospit 24 hours Funera etely fille	edical (29a. Certifier 1 ☐ Certifying (Check only one) 2 ☐ Medical E	Physician: To the xaminer: On the ba and mann	ania of ovamina	tion and/ar in.		and the same of the same					ated. the cause(s)	
	To th within To th compl	Me	29b. Signature and title of certifier		Do	out	29c. Lice	ense number		290	d. Date signe	d (Month, E	Day, Year)	
	,		> //bille	. (1)	7		D	060	54	J	AN. 16	5,2004	, 	
	V		30. Name and address of person w	no completed cars	e of death (I em	23a) (Type.	Print)							
	•		WILLIAM P. JO	ONES MD	69	5 A	merie	cn	CX.	21	033	5		
	Sta Registr		21 Date filed (Month Day Veer)	6 2004 ^{32. Ri}	e of death (len	ture ?	James !							

			1 = For Stete Registrar	State of M		epartment of Certificate o		Mental Hygier	_ / U U L	00864
			Decedent's Neme (First, Middle, La	st)				2. Date of Death		3. Time of Death
	Physicia		John Elva Davis						13 , 200°	43145 CLM
	/Medic Examin		4a. Fecility Name (If not institution, giv	e street and number	r)	4b. City, Towr	, or Location of Dea		4c. County of Dea	
	Examin	EI	ST Aques	HEALT	-1 4	- BA	To M	d.	Not App1	icable.
	Funeral		5. Social Security Number 6. S		age (In yrs. last birth	nday) If Under 1 Ye	ar If Under 24 Hrs	8. Date of Birth	9 Bin	tholace (State or Foreign
	Director		222-10-6403	M M 2□F	86 Y	rs. Months Day	s Hours Min	March 27,	1917 Ma	ryland
	ס		Usuel Residence of Decedent							T
	how		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Ma B-f	cto	Maryland Not App	licable	Balti	imore				1 XYes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Cod	9	10g. (Citizen of What Co	ountry?
	th wi		616 South Pays	on Street		2	1223	Un	ited St	ates
	eep .	Funeral	11. Marital Status	12. Was Deceder Armed Forces	t Ever in U.S.	13. Was Decedent of If Yes, specify C	of Hispanic Origin? (Suban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit	
9	or it	F	1 Never Married 2 Married	1 XYes 2 If Yes, Give	17/1941-	1 ☐ Yes 2 ☒ I			Specify:	
8	urei',	d by	3 Widowed 4 Divorced							White
<u>.</u>	be filed within 72 hours after death with the Maryland that lygiene. ad other than "natural", or items 23a or 28a-f show of other than "natural", or items 23a or 28a-f show event, the Madical Examinat must be natilised a	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a.	Decedent's Usual Oc (Give kind of work do life. DO NOT use rel	ne during most of wo	orking 16b.	. Kind of Business	/Industry
12	han han	m	Elementary/Secondary (0-12)	College (1-4o	r 5+) Δ1:	itomobile .	,		Automob	1 10
2	lled v tygie ther t		17. Father's Name (First, Middle, Last)	710	comodite.		me (First, Middle, Maid		TIE
and	I be filed ntal Hygi ed other: event,	Be							or our arroy	
Ž	2 should be filed withir and Mental Hygiene. Ie marked other than aumatic event, the Ma	우	Vaughn R. Davis 19a. Informant's Name/Relationship (Tuna Print)	19h	Mailing Address (Str		y Davis Jural Route Number, Cit	y or Town State	Zin Codel
Ma	d 2 st h and 7 ier		Johanna Weidne					altimore, M		
e,	ges 1 and 2 should t of Health and Men If Item 27 ie marke or other traumatic	1.8	20a. Method of Disposition						Lary Land Location - City or	
و	in of or o	1	1 ☑ Burial 2 ☐ Cremation 3 ☐			Disposition (Name of crematory or other)				
ij	t. Partmer		*4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice)	0 (-1	Loudon	22. Name and Ad		. 16, 2004	Baltimore	e, Maryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra	9 6) Office	S. Joff	erson	Loudon Pa	ark Funera kens Avenu	ie, Baltimo	re, Mary	land 21229
- 85			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that faus	ed the death. Do n line.	ot enter the mode of	tying, such as cardia	c or respiratory arrest,		Approximate Interval Between
	Physician		tmmediate Cause (Final disease or condition	5 2	EPS15					Onset and Death
	/Medical		resulting in death)	Due to (or a	is a consequence of	f):	17			
λ.	Examiner		Savuontially list conditions	001	VGESTI	VE HEA	RI + AT	LURE		
	₽ ≅	ner	E-quantially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	s a consequence of	n: FAILU	0=			
	ecute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C						
90,	death certificate be executed e attending physician and of for use as the burial-transit	ũ	1930tting in Goath) Last	Due to (or a	is a consequence o	T):				
8760,	ate b hysic the b	dical		_ d						
9	entific ling p	Me	IF FEMALE:	00 W	27.53			all:		
Вох	leath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 Ectopic pregna			23d. Date of dei	livery Day Year
		sic	1 Yes 2 No	4∐Pregnant 9☐ Unknown	at time of death	5 Other (specify,)			,
P.O.	ac ac	Ρh	Part II. Other significant conditions	contributing to death	but not resulting in	the underlying cause	gwen in Part I	23e Did tobacc	o use contribute to	the cause of death?
S,		by	Part II. Other significant conditions	contributing to death	but not resulting in	the underlying cause	given in Parti.	1 ☐ Yes		robably 4 Unknown
of Vital Records,	requires sen sign hould be	Completed							2)4(10 00)	
ec	CG VI CV	nple						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
H	Th ate pag	S						performed 1 ☐ Yes 2		2 X No
/ita	ysicien: Th is certiticate director, pag	Be	25. Was case referred to medical examiner?	Harakat as				ath (Check only one)		
=	Physicien: this certitic ral director,	မ	1 ☐ Yes 2 XNo	Hospital: 1 XInpa		patient 3 DOA		Home 5 Residence		cify)
n o	After uners	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of In (Month, L	njury 28b. T Da <i>y Year)</i> In	jury V	Vork?	28d. Describe how in	njury occurred	
Sic	tend leath tor: / the f	cat	2 Accident investigation 3 Suicide 6 Could not be				☐Yes 2☐No	201 Lanatina (Cture)		
Division	el or Al s after o il Direct d in by	Certification;	4 Homicide determined	building,	etc. (Specify)	m, street, lactory, offi	CB .	28l. Location (Street City or Town, St	ate)	arar Houte Number,
12	To the Hospitel or Attending Physic within 24 hours after death. To the Funeral Director: After this or completely filled in by the funeral directors.	edical (29a. Certifier (Check only one) 1 Certifying Pl	nysician: To the be- miner: On the basis and manner	of examination and	death occurred at the Vor investigation, in m	e time, date and plac by opinion, death occ	e, and due to the cause urred at the time, date a	e(s) and manner as and place, and due	s stated. e to the cause(s)
	othin othin ompl	Me	29b. Signature and title of certifier				ense number		Date signed (Mont	
	/- > - 0		1 Tecctora	Nicuel	enen 17	D P	17605	JA	NUARY	13,2004
	all		30. Name and address of person who	completed cause of	f death (Item 23a) (Type, Print)	EMITH	ARE	BALTIM	DOE MA
	Sta		30. Name and address of person who TEODORA MICULA 31. Date filed (Month, Day, Year)	32. Regis	strar's gnature	10 M.	Ma.	11100 /		re / 110
4	Registi	ar	JAN	TO ZUUM	fall of come	NI SOSTA				

			1 - For State Registrar	State of Marylan		ent of Health and ate of Death	Mental Hygie		+ 00865
	Physici /Medic Examir	al	1. Decedent's Name (First, Middle, Last 4a. Facility Name (If not institution, give	Ebert	/ 4b. Ç	y, Town, or Location of Dea	2. Date of Death Month	Day Year 2004 4c. County of Deat	3. Time of Death 4105A M
	Funeral Director		5. Social Security Number 6. Se 2/2 - 0.5 - /49/ Usual Residence of Decedent	WHULLAN KT x 7. Age (In yrs. M 2DXF	last birthday) If Und Yrs. Month	der 1 Year If Under 24 Hrs s Days Hours Min		9. Birt Co 1/8	thplace (State or Foreign nuntry) Lyland
	the Maryland	ector	10a. Slate 10b. County 10e. Street and Number	10c. Cit	y, Town or Location)			10d. Inside City Limits 1 Yes 2 No
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Itama 23s or 28s-f show any injury or other traumatic event, I'm Medical Ensis is at mass the inclitical at once.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces? 1 Yes Cive	.S. 13. Was Dec	Zip Code 2/2/2/7 pedent of Hispanic Origin? (5 pecify Cuban, Mexican, Puer 2/2/No Specify:	Specify Yes or No-	14. Race - Ame Black, White	ncan Indian,
21215-0036	I within 72 hours iene. r then "natural", to Medical Exe	ompleted by	3 Widowed 4 □ Divorced 15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		16a. Decedent's U	sual Occupation	rking 16b	Specify: Wood Susiness/	Industry COM.
Maryland 2	should be filed ind Mental Hygi marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last)	Baker	Just	Sac	me (First, Middle, Maid	OX	
	1 and 2 sho Health and Iom 27 io m		19a Info ma t's Name/Relationship (T)	Shrok	309 Ma	ss (Street and Number or R	ptown, 1	UD 218	61
Baltimore,	permit. Pages 1 a Department of Hea Important: If item any injury or othe once.		20a. Method of Disposition 1 Aburial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature Funeral Societions	Removal from State	Place of Disposition (Nemetery, crematory of Reluxed Me) 22. Name	and Address of Facility	Date 200 16004 Pa	Location - City or	Town, State
ä	Depa Depa Impo any is		23a. Part1, Enter the disease, or comp	ications that caused the deat	8800	HARFORD A	Balt or respiratory arrest.	IMORO I	Approximate
	Physician /Medical		shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequence of the consequence		mer's Dise	'age		Interval Between Onset and Death
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury	b. — Due to (or as a consequ					
8760,	ate be executed hysician and the burial-transit	Ical Examiner	that is distant assessed	Due to (or as a consequent	uence of):				
.O. Box 68	ath certific titlending p or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de	I death 3 □Ectopic			23d. Date of deliment	very Day Year
rds, P.	quires that the de n signed by the a ud be detached f	by	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the underlying	cause given in Part I.	23e. Did tobacc		the cause of death?
al Records,	n: The law require Icate has been si r, page 2 should t	Completed					24a. Was an autopsy penformed 1 🗆 Yes 2 🖸	prior to c death?	topsy findings available ompletion of cause of
Ž	ding Physician: The I h. After this certificate ha funeral director, page	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2	ER/Outpatient 3 []	Other	ath <i>(Check only one)</i> lome 5 \(\text{Residence} \)	6 □Other (Spec	ify)
Division of Vital	Attending Physician: r death. ector: After this certifice by the funeral director.	atlon;	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury al Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	ijury occurred	
Divis	i i i i i i i	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, street, facto /)	ory, office	28f. Location (Street City or Town, St	and Number or Rui ate)	ral Route Number,
7	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death occurre tion and/or investigation	d at the time, date and place on, in my opinion, death occu	, and due to the cause rred at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	To th To th compl	Me	29b. Signature and title of certifier		2	9c. License number		Date signed (Month	
•			30. Name and address of person who co	ompleted cause of death (Item	23a) (Type, Print)	037573		an 15,	
	4		31. Date filed (Month, Day Year)	Zibell 3	Tura No.	St. Krist	esta	MD SIE	36
	Sta Registr		JAN	1 6 2904 /	Com St.	Prouts)			

				State of Ma	cei	rtificate of		Mental Hy	giene Reg. No.	004	00860
No.	Physici /Medio		1. Decedent's Name (First, Middle, Las Charity Mo	ay Fro	aker			2. Dete of De Month	Dey_	Year 2004	3. Time of Death 7:09 PM
3	Examin	er	4e Fecility Neme (If not institution, give COPOLY RICHS) 5. Social Security Number C. Si	2	(In yrs. lest birthday)		4b. City, Town, or VKES V	Location of Deat	Car	100m	/
	Funeral Director			M 2170 F 83		Months Deys	Hours Min		⁹ 1920	9. Birthpi Count	ace (State or Foreign Inc.) Missouri
	laryland ahow	5	10a. Stete 10b. County MD Carr	011	10c. City, Town or Lo					10	0d. Inside City Limits 1 ☐ Yes 2√☐ No
	ath with the Maryland a 23s or 28s-f show	Funeral Director	10e. Street end Number 3335 Lawndale Roa		ке	isterstow 10f. Zip Code 211			10g. Citizer of USA	What Count	
020	72 hours after daath with the Maryland natural, or itema 23a or 28e-f show Steal Examiner must be notified at	by Funer	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates:	ver in U,S. 13. \	Was Decedent of H f Yes, specify Cube 1 Yes 2 No		Specify Yes or No to Rican, etc.)	3- 14. Rac Bla Specif	ca - America ck, White, e	etc.
21215-0020	Jwithin 72 ho liene. r than "naturi the Medical I	Completed by	15. Decedent's Ed (Specify only highest gred Elementery/Specondary (0-12)		-)	dent's Usuel Occup kind of work done of DO NOT use retired		nrking	16b. Kind of B		ustry s / Domesti
Maryland ?	ould be filed Mental Hyg mrked other mtic event,	To Be C	17. Father's Neme (First, Middle, Last) James Tippi					me (First, Middle		ne)	7 Domeses
	es 1 and 2 sh of Health and I Item 27 is m r other traum		19a. Informant's Name/Relationship (7) Mrs. Kartina High 20a. Method of Disposition 1□ Burial 2 MCremation 3□	(Daughter)		Ig Address (Street of Lawndale sition (Name of netory or other place	Rd. Re			21136	•
Baltimore,	permit. Pages Department of Important: If it eny Injury or o		4 Donation 5 Other (Specify,		All Count	y Cremat Name and Addres HAIGHT FU	ion Srv Ss of Facility NERAL HO	ME & CHA	APEL, PA	(Box	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the cause on each line	he death. Do not ente	Sykesvil	le, MD 2	1784 (41	.0)-795-	1400	Approximate Interval Between
	Physician Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	. Dem	ientia		· · · · ·				Onset and Death
	cuted nd ransit	amlner	Sequentially list conditions.	Dehy	dratio (or es e consequence to (or as e consequence to	<u>n</u>				6	days
	E 0 a	<u>8</u>	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last	. Diarr	ne to (or as e consequ	uence of):				V	veeks
, P.O. Box	The law requires that the death cer ate has been signed by the attendir page 2 should be datached for use	Be Completed by Physician/N	Part II. Other significant conditions con Othial fibrilla	ntributing to death but	not resulting in the un	iderlying cause give	en in Part I.			,	the cause of death?
Records,	e law require: has been sig je 2 should b	mpleted b	ischemic atto	ick, hy	perten	sion,	Janon	24a. Was perfo	en autopsy rmed?	avai	e autopsy findings lable prior to pletion of cause eath?
Vital	ysician: The	To Be Co	25. Was case referred to medical examiner?	1 □ Inpatient	2 ER/Outpatient	3 DOA OTHE	-	ath (Check only o	ne)		Yes 2□ No
Division of Vital	To the Neptial or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this cartificate he completaly filled in by the funeral director, page	Certification:	27. Menner of Deeth 1	28e. Date of Injury (Month, Dey 1	Year) 28b. Time of Injury			28d. Describe h	ow injury occurr	red	
DIV	ours after of here of the or of the	al Certif	4 ☐ Homicide determined	28e. Plece of Injury building, etc.			e date and place	City or Tow			
	To the Hospital within 24 hours a To the Funeral I completely filled		(Check only one) 2 Medical Examination (Check only one)	ner: On the besis of each manner state	xeminetion end/or inve	estigation, in my op	inion, death occu	rred at the time, o	date and place, a	and due to ti	he cause(s)
			30. Neme end address of person who co	mpleted cause of dee	th (Item 23e) /Tune P	000	5813	7	29d. Date signed	104	ıy, 10ai)
	Stat		31. Dete filed (Month, Day, Year)	the a	recht le	2d. Sy	Kesui	Ile, M	P 217	84	
	Pogistra		1 微 i 1	E DOOL A	See At	20					

			lease	Type or Prin State of Ma					-		•	-
		1 - For State Registrar			-	-	icate of			Reg. No	200	4 00867
Physici	an	1. Decedent's Name (First, I Melba M			·				2. Date of D		y tin Yea	3. Time of Death
/Medie		4a. Facility Name (If not insti				41	o. City. Town	or Location of Dea	Lanuc		. County of De	04 1045 PM
Examili	ier	Franklin Sou	_		Cent		2050	طماح			-	nore
Funeral		5. Social Security Number 215-10-3229	6. S		e (In yrs. last birt	thday) 1	Under TYear onths Days	If Under 24 Hr. Hours Min		irth Day, Year)	9. E	Birthplace (State or Foreign Country) WULAND
Director		Usual Residence of Deceder		^	74	113.			May 2	8, 19	109 M	aryland
arylan show	_	10a. State 10b. Co			10c. City, Town							10d. Inside City Limits
the M 28a-f	Director	Maryland Bas	Etimo	re			1 Hall 101. Zip Code			10a Cit	izen of What	1 ☐ Yes 2 ☑ No
h with 23a or		13 H Brook	Farm	Ct.				21128			S.A.	Country
ar deat	Funeral	11. Marital Status		12. Was Decedent Armed Forces?		13. Was	Decedent of H	Hispanic Origin? (an, Mexican, Pue	Specify Yes or N	lo-	14. Race - Ar Black, W	nerican Indian,
Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Maryland it and Mental Hyglene. It is marked other than "natural", or Itams 23e or 28e-f show traumatic event, its Medical Examinar must be notified at	by	1 ☐ Never Married 2 ☐ 3 🛣 Widowed 4 ☐ Divo		1 □ Yes 2 1 1 If Yes, Give Year or Dates:	No	1	Yes 2 No				Specify:	White
72 ho	Completed	15. Dec (Specify only h	edent's Ed	ducation ade completed)	16a.	Decedent (Give kind	's Usual Occup	pation during most of wo	orking	16b. K	ind of Busines	ss/Industry
within within	ошр	Elementary/Secondary (0-8th Grade	12)	College (1-4or 5	5+)		NOT use retire. 1emaker				Own H	ame
of filed of the other	Be C	17. Father's Name (First, Mic	ddle, Last)	-			Tanta C C	7	me (First, Middl	e, Maiden		ome_
aryland 212 2 should be filed with and Mental thygiene, is marked other tha	To		stner					Mar			ie Unkn	
Mar nd 2 sh nith and 27 is m r traum		19a. Informant's Name/Rela Mrs. Jean Ed	. , ,					and Number or A arm Ct.,				, Zip Code) 1128
She she she she she she she she she she s		20a. Method of Disposition			20b Place of	Dispositio		o ite	Date			or Town, State
Fick Baltimore, Semit. Pages 1a Department of He, Monotrant: If item mny injury or othe		1 XBurial 2 ☐ Crema 1 4 ☐ Donation 5 ☐ Oth				awn C	emeter.	y 1/1				Maryland
Baltimo Permit. Pages Department of Important: #i any injury or a		21. Signature of Funeral Ser	vice Licen	W 200	11-10-10-10-10-10-10-10-10-10-10-10-10-1	22. Na	ame and Addre	oss of Facility Scair Rd.,	himunek Baltim	Fune	ral Ho	mes 26
		23a. Part1. Enter the diseas shock, or heart failure.	e, or com	plications that caused	the death. Do n						MV ZIZ	Approximate
Physician		Immediate Cause (Final disease or condition	List only					r Acc				Interval Between Onset and Death
/Medical Examiner		resulting in death)		Due to (or as	a consequence o	of):	<u>Curu</u>	1 116	JICIE!	17		
	er	Sequentially list conditions,		b. Due to (or as	Jenzy Leonsequence	Q F	1				-	
cuted od ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1	« Cono	esti	ve	Hear	+ Fai	luce			
'60, be executed sician and burial-transit	al Ex	resulting in death) Last		Due to (or as	consequence o	of):						
Box 687(Jeath certificate be attending physic	edica			d								
OX (h certi	M/U	IF FEMALE: 23b. Was decedent pregnant	t	23c. If yes, outcome	of pregnancy 2 ☐ Fetal death	ه ال⊏من	opic pregnancy			2	23d. Date of d	elivery
Vision of Vital Records, P.O. Box 687 Attending Physician: The law requires that the death certificate riceath. Totakh. actor: Attenthis certificate has been signed by the attending phys by the funeral director, page 2 should be detached for use as the	by Physiclan/Medic	in the past 12 months? 1 ☐ Yes 2 X No 9 ☐ Unknown		4☐Pregnant at 9☐Unknown			ner (specify)				Month	Day Year
	y Ph	Part II. Other significant cor	nditions o	ontributing to death bu	ut not resulting in	the under	lying cause give	en in Part I.	23e. Did	tobacco u	se çontribute	to the cause of death?
Division of Vital Records, tor Attending Physician: The law requires that after death. Director: Director the this certificate has been signed in by the funeral director, page 2 should be contact.	ed b	- 							1 🗆	Yes 2	X No 3□F	Probably 4 Unknown
Recc e law re has be	Completed								24a. Was		24b. Were a	autopsy findings available completion of cause of
al Re n: The l icate ha	S.								perf	ormed? 2 No	death?	s 2□No
on of Vita ding Physician: h, After this certific funeral director,	To Be	25. Was case referred to me examiner? 1 Yes 2 No	dical	Hospital: 1 Inpatie	nt 2□ER/Out	nationt 3	□ DOA Oth	or	ath (Check only			16 - s
ng Phy ng Phy ter this	T:uc	27. Manner of Death		28a. ate of Injur (Month, Day	y 28b. Ti		28c. Injun	v at	lome 5 Res 28d. Describe			ecity)
isior ttendin death. ctor: Aff	catic		ending restigation ould not be				1 1 1	Yes 2 □ No				
Divi	Certification:		termined	28e. Place of Inju building, etc	iry - At home, farr c. <i>(Specify)</i>	m, street, 1	actory, office		28f. Location (City or To	Street and wn, State)	d Number or F	Rural Route Number,
Divisio To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one)	ifying Ph	ysician: To the best on the basis of and manner sta	examination and	death occ	urred at the tim gation, in my of	ne, date and place pinion, death occu	a, and due to the urred at the time,	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)
To the within To the comple	Me	29b. Signature and title of ce	rtifier	and mailings sta			29c. License	e number		29d. Date	signed (Mon	th, Day, Year)
O . ,		\$ 50,000	300	2 MI)			RRS	00000	0	-1	12/0	4
0		30. Name and address of per	san who	completed cause of de	eath (Item 23a) (T	Type, Print)	<u></u>	0			
Sta		31. Date filed (Month, Day, Y	(ear)	32. Registra	TOAKLI	rn 2	quare	LUnve	, bult	m	DL6 W	D SIB37
Registra			MA	1 6 2004	Bergue	, J.	1300	زي				

Bettye Fish hein

VOID

CERTIFICATE

2004-00868

SEE

CERTIFICATE #

2004-3373

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 1128 Stanley Fields January 07,2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimor Healthcare Under 1 Year | If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) Jan 7, 195 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sev **Funeral** Days 1 K 1 M 2 □ F 214-56-8137 53 Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State unk 10b. County in then "natural", or Items 23s or 28s-f show the Madical Exerciter must be notified at unk unk 1 ☐ Yes 2 ☐ No Director 10g. Citizen of What Country? 10e. Street and Number unk 10f. Zip Code unk USA unk 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: unk 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify black þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk d 2 should be filed within 7 th and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unk 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health at Important: If item 27 Is any injury or other traugnes. St. Agnes Healthcare 900 S. Caton Avenue Baltimore, MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 Donation 5 NOther (Specify) in state 21. Sonatore of Euneral Service Licensee Ronald S State Anatomy Board 655 W. Baltimore Street mun 21201 Baltimore, MD Part1. Enter the disease/or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) myocardial Vakanus Physician infarchion /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner use as the burial-trar Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12, months?
1 □ Yes 2 □ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ page 2 should be 1 Tes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2/3 No **Division of Vital** After this certific funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X ER/Outpatient 3 □ DOA 1 Yes 2 No Medical Certification: To 27. Manner of Teath 28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide within 24 hours after de To the Funeral Directo completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier D4735 7,2004 JANVAY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bultmore, Maryland Cuton Avenue JON FALCK MD 900 \$2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 1 6 2004

			For State of Maryland		artment of F		d Mental Hy	giene 2	004	00870
	Dhyair	ion	Decedent's Name (First, Middle, Last)				2. Date of De Month	eath Day	Year	3. Time of Death
	Physic /Med		Doris E. Gress				Januar		2004	4:00 A M
V	Exam	iner	4a. Facility Name (If not institution, give street and number) Stella Maris		4b. City, Town, o		Jeath .		inty of Death Balti	
	Funera Directo		5. Social Security Number 6. Sex 1 ☐ M 2 ☒ F 85	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Bi (Month, D. March	rth ay, Year) 29,191		place (State or Foreign intry) UYLand
,	and *		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Lo	ecation			- 1		10d. Inside City Limits
	Maryli f sho	ğ	Maryland Baltimore		Baltimore					1 □ Yes 2 🂢 No
	th the or 28a	Director	10e. Street and Number		10f. Zip Code			10g. Citizen		
	s 23a	ral	4104 Perryview Road			21:			u.s	
000	DENLIMOTE, INITYIATIO Z IZ I 3-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show many highry or other traumatic event, Ita Medical Experimental Internalised and	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hilf Yes, specify Cuba	lispanic Origin an, Mexican, F Specify:	? (Specify Yes or No Puerto Rican, etc.)		Race - Amer Black, White ecity: Wh	, etc.
Č.	72 ho	eted	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup	durina most o	working	16b. Kind o	f Business/li	ndustry
Č	within then	Completed	Elementary/Secondary (0·12) College (1·4or 5+) 12th Grade	life.	DO NOT use retired LETK	d)		Ro	tail	
7	filed Hygid other	Be Co	17. Father's Name (First, Middle, Last)			18. Mother's	Name (First, Middle			
	uld be Wenta Wenta Irked	To B	Elmer Dietz			The	eresa Mi	vrphy		
	i, Maryla and 2 should saith and Men n 27 is marke ier traumatic	E 15	19a. Informant's Name/Relationship (Type, Print)				r Rural Route Numb			p Code)
AM	1 and 1 and Health em 27	1	Mr. Steven Faulkner (grandson) 20a. Method of Disposition	ace of Dispo	sition (Name of		Date		2 1 0 4 7 on - City or T	own, State
00:	ages ant of ht: if it		1 Neurial 2 Cremation & Removal from State	metery, crer	natory or other plac Mem'l Pau		14/2004			
4	DENILIMOTE, INICITYICIA Z I Z I D-UUJO permit. Pages 1 and 2 should be filed within 72 hours alt Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or any injury or other traumatic event, I a Maulcal Expin		21. Signature of Funeral Service Licensee	22	2. Name and Addre	ss of Facility	Schimunek , Battimo	Funer	al Hon	nes
			23a. Part1. Enter the disease, of complications that caused the death. shock, or heart failure. List may one cause on each line.							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	,						Onset and Death
	/Medica Examine		resulting in death) Due to (or as a consequence)	ence of):	lese 125	1				
	b	e.	if any leading to immediate Due to (or as a Conseque	ence of).	escoll)	XICC	Ellert			
	icate be executed physicien and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	Cario	1					
9	of ou, cate be executed physicien and the burial-transit	EX	resulting in death) Last Due to (or 35 5 consequence)	ance of):						
i	filicate the part the k	dlcal	d		-					
2004	death cert e attending	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)	1		1	Date of deliv Month	rery Day Year
7	s that the	by Ph	Part II. Other significant conditions contributing to death but not result					tobacco use c	ontribute to	the cause of death?
$\langle Y \rangle$	COLOS, P. Wrequires that is been signed it should be detailed.	ed b	Vr. ney Jacontinench				_ 10	Yes 2□No	o 3∏Pro	bably 4 Sunknown
JANUARY	UNISION OF VIKAL RECORD If or Attanding Physician: The law requir after death. Director: After this certificate has been si d in by the funeral director, page 2 should	Completed	Convertised Beginner	Est 1	Dist D	16616	24a. Was auto perfi 1 Yes	s an 24 psy ormed? 2 No	b. Were auto prior to co death? 1 Yes	opsy findings available ompletion of cause of 2 No
, ,	Of VICE Physician: this certific ral director,	Be	25. Was case referred to medical examiner?		Oth	00	Death (Check only			
GRESS	Phys r this c	년 2	Tigres 2 No Tigratient 2 E	R/Outpatien 28b. Time of	it 3 DOA	Nursi	ng Home 5 Res 28d. Describe			(fy)
GR	ONISION or Attanding latter death. Director: After in by the funer	Certification;	1 ☑Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury		k? Yes 2⊡No				
SI	r Atta	tifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location (City or To	(Street and Nu wn, State)	mber or Rur	al Route Number,
DORIS	lospital or A hours after uneral Dire	Cer								
,	the F	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examinating and manner stated.	iedge, death on and/or in	h occurred at the tir vestigation, in my o	pinion, death	place, and due to the poccurred at the time,	date and place	ce, and due t	o the cause(s)
	To Toon	-	29b. Signature and title of ceptifier			1283		29d. Date sig	gned (Month,	Day, 19di)
	C ₂		30. Name and address of person who completed cause of death (Item	23a) (Tyne		0 -00		1111	109	
	0				VALLEY F	ROAD T	IMONIUM,	MD 2109	93	
		tate	31. Date filed (Month, Day, Year) 32. Registre's Signatu JAN 1 6 2004							
	Regis	trar	JAN I O ZUU4 P JARTIGAL	B STORE	A STATE OF LAND					

			1 - State of Mar State of Mar Registrar	•	artment of H rtificate of L			ene . No. 20 (00871
	Dhusisi		Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Ye	3. Time of Death
	Physicia /Medic		Agnes G. Gavin				01/13/	2004	7:00P M
	Examin	er	4a. Facility Name (If not institution, give street and number)	3 . 1		Location of Death		4c. County of D	
			Mariner Health of N. Aru 5. Social Security Number 6. Sex 7. Age (Indel (In yrs. last birthday)	Glen Bu		8. Date of Birth	Anne A	
	Funeral Director		1□N 3186E	3 Yrs.	Months Days	Hours Min.	12/24/1	910	Birthplace (State or Foreign Country) MD
	ס		Usual Residence of Decedent			I			
	anylan show	L.	,	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 📉 No
	Ba-f.	ecto	MD Anne Arundel	Pasade			1.0		
	death with the Maryland ms 23a or 28a-f show critist Let malified at	Funeral Director	10e. Street and Number		10f. Zip Code			. Citizen of What	Country?
	eath	erai	1586 Melanie Rd. 11. Marital Status 12. Was Decedent Ev	er in U.S. 13.	21122 Was Decedent of Hi			U.S.A.	merican Indian,
_	r Iten	뎚	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 1 □ No		If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Black, V	Vhite, etc.
2-0030	rel', o	ξ	3 Ma Widowed 4 □ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 🗷 No	Specify:		Specify:	White
ر م	72 h 'natu	Completed by	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of work	ing 16	b. Kind of Busine	ess/Industry
V	within ane.	m d	Elementary/Secondary (0-12) College (1-4or 5+)		les Cler		i	Depart	man t
N 0	Hygle ther i	e Co	17. Father's Name (First, Middle, Last)	Ja.	rep crei		e (First, Middle, Ma		menc
yiand	ld be ental ked o	To Be	Isadore Burkhardt			Minnie	Behner		
2	shou nd M mer	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street a				e, Zip Code)
Ma	and 2 alth a 27 is		Dennis H. Gavin/Son	1586	6 Melani	e Rd., E	asadena	,MD 21	122
e,	of He of Her		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Dispo cemetery, crer	sition (Name of matory or other plac	е)	Date 20	c. Location - City	or Town, State
Ĕ	Pag ment ant: I		'4 □ Donation 5 □ Other (Specify)						rnie, MD
Бант	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Hyporant: If item 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other traumetic event. The Medical Example, or other traumetic event, The Medical Example, or other traumetic event.		21. Signature of Funeral Service-Licensee		2. Name and Addres	0.			al Home, PA 21122
			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line	ne death. Do not ent	er the mode of dying	g, such as cardiac	or respiratory arres	,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	lea Ku	ext to	dure			Onset and Death
	/Medical Examiner		resulting in death) Due to (ir as a	consequence of):	1	0000			0
	LXammer	e e	Sequentially list conditions. b. Due to locas a	consequence of	-				
	ted nsit	in in	cause. Enter Underlying Cause (Disease or injury	ourse quartos orp.					
,	be executed ician and burial-transi	Examin	that initiated events c	consequence of);					
2/00	cate be executed ohysician and the burial-transit	dicai	d						
ŏ	certificate nding phys Ise as the	Ø.	IF FEMALE:						
ŏ	w requires that the death certific been signed by the attending p should be detached for use as i	hysician/M	23b. Was decedent pregnant in the cast 12 months?	Fetal death 3	Ectopic pregnancy			23d. Date of Month	delivery Day Year
5	the atten the atten hed for u	/sici	1 ☐ Yes 2 ☒ No 4 ☐ Pregnant at tir 9 ☐ Unknown 9 ☐ Unknown	me of death 5	Other (specify)				54 ,
Ţ.	requires that the een signed by th nould be detache	۵.	Part II. Other significant conditions contributing to death but	not resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	cco use contribut	e to the cause of death?
gs,	uires slgn ld be	d by	Perchand Vasculor dis	ofe			1 ☐ Yes	2 No 3	Probably 4 Unknown
Cord	law req as beer 2 shou	ompieted	7				24a. Was an	24b. Were	autopsy findings available
Ĕ	'sicien: The law s certificate has t lirector, page 2 s	E G			•		autopsy performe	d? death	
VII	en: 7 tifical tor, p	C	25. Was case referred to medical			26. Place of Deat	1 ☐ Yes 2 ☐ h (Check only one)	No 1 L	res 250 No
_	Physicien: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient	2 ER/Outpatier	nt 3□ DOA Othe	er: 4 Nursing Ho	me 5 Residenc	e 6 □Other (S	Specify)
0	ding Physicien: h. After this certific funeral director,		27. Manner of Death 28a. Date of Injury 1 Senatural 5 Pending (Month, Day)	Year) 28b. Time of Injury	Work		28d. Describe how	injury occurred	
<u> </u>	tendi leath. for: A the fu	rtification:	2 Accident investigation			Yes 2 □ No	006 1 1 (0)		
UIVISION	or At after d Direct in by	i#	4 Homicide determined 28e. Place of Injury building, etc.	y - At home, farm, str (Specify)	reet, factory, office		City or Town,	et and Number oi State)	r Rural Route Number,
	spitei ours a perel i	o Ce	29a. Certifier 1 (2) Certifying Physicien: To the best of	mv knowledge, deati	h occurred at the tim	ne, date and place,	and due to the caus	se(s) and manner	as stated
	~To the Hospitel or Attending Pr within 24 hours after death. To the Funerel Director: After to completely filled in by the funera	edical	(Check only 2 Medical Examiner: On the basis of e and manner state	xamination and/or in					
	To th withir To th compl	Me	29b. Signature and title of certiful		29c. License	e number	29d	. Date signed (M	onth, Day, Year)
,	:		> Who max		1 3	8958	1	115/2	204
			30. Name and address of person who completed cause of dea	ath (Item 23a) (Type,	Print)	11	+106 0G	1 +	44 7 4 345
			Dateet Singh Sulling	1413 Mm	nepolite.	KOAU Z	F106 04	enten	MD211/3
	Sta Registr		31. Datè fill d (Month, Day, Year) 1 6 2007 Registrar	s Signature	S. C. C. C. C. C. C. C. C. C. C. C. C. C.				
	-								

			1- State of Maryland / Department of Health and Mental Hygiene 2 0 0 1 0 8 7 2 Certificate of Death Reg. No.
	Physici	an	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 3. Time of Death Month Day Year 11 00 M
) }	/Media	cal	$(0) \qquad \qquad (0) \qquad \qquad (0) \qquad \qquad (0) \qquad \qquad (1) \qquad (1) \qquad (1) \qquad \qquad (2) \qquad \qquad (2) \qquad \qquad (3) \qquad \qquad (4) \qquad \qquad $
	Examir	ner	4a. Facility Name (If not institution, give street and number) 4b. Six Town, or Location of Death 4c. County of Death
	Funeral		5. Social Security Number LTDK 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
f2e	Director		59 "s" Dec 12, 1944
	and		Usuel Residence of Decedent Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	Many	to	MD Baltimore 1∑ Yes 2 □ No
	or 282	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	ath wi		32 S. Calouton Road 21223 USA
	er de:	Funeral	11. Marital Status Unk 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
36	be filed within 72 hours after death with the Maryland tal Hyglene. Id other than "natural", or Items 23a or 28a-1 show event, the Medical Evanitry mast be redified at		1 □ Never Married 2 □ Married 1 □ Yes 2 □ No unk 1 □ Yes 2 □ No Unk 1 □ Yes 2 □ No Specify: Specify: Specify: black
Š	72 hou	ted	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working
21215-0036	filed within 72 Hygiene. kther than "naf ant, the Medic	Completed by	Elementary/Secondary (0-12) College (1-4or 5+)
2	filed w Hygier other ti	ő	unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Meiden Sumame) unk 18. Mother's Name (First, Middle, Meiden Sumame) unk 18. Mother's Name (First, Middle, Meiden Sumame) unk
au		o Be	17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Meiden Surname) unk
Maryland	S D E E	ဥ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	1 and 2 Health a tem 27 ls		Bon Secours Hospital 2000 W. Baltimore Street Baltimore, MD 21221223
Baltimore,	jes 1 and of Healt if item 2 or other		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State
Ě	. Pages tment of tant: If it jury or o		`4 □Donation 5 图 Other (Specify) in state
g	permit. Pages Department of I Important: If it any injury or o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street
			23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on sach line. Approximate Interval Between
,	Physician		Immediate Cause (Final Onset and Depath
12	/Medical		disease or condition resulting in death) a Cety HCTON Pept C VICE 24/15
	Examiner		Sequentially list conditions b. The 2 mon 1 A
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury
•	xecut	хап	resulting in death) Last C Due to (or as a consequence of):
8/60	icate be executed physician and s the burial-transit	dical	
Q	certificat nding phy use as th	Medi	
o n	wrequires that the death certific been signed by the attending f should be detached for use as	ician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy Month Day Year
5	the a	ysici	In the past 12 months? 1 Yes 2 No
ŗ	requires that the een signed by th hould be detache	/ Physi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. / 23e. Did tobacco use contribute to the cause of death?
S	quires n sign ald be	d by	HUMANIMMONODOFKIONY VIVE INTECTION 1 Yes 2000 3 Probably 4 Unknown
ecords	law rec as bee 2 shou	piete	Dougho MAINITY (TDA) 24a. Was an 24b. Were autopsy findings available
r	iclan: The lav certificate has rector, page 2	Completed	autopsy perfor to completion of cause of performed? death? 1 □ Yes 2 No 1 □ Yes 2 □ No
N Ea	clan: ertifica	Bec	25. Was case referred to medical according to the seminer?
5	Physiclan: this certific ral director,	ဥ	1 Yes 2 No Hospital: Vinpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
	ding P. h. After funer	tion	27. Manner of Death Altural 5 Pending 28a. Date of Injury 28b. Time of Injury
JIVISION	Attending r death. ector: After by the fune	fica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number.
5	s after	Certification:	4 Homicide determined building, etc. (Specify)
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical (29a. Certifier (Check only (C
	thin 2, the I	Medi	and manner stated.
	Z = Z = Q	-	29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)
			30. Name and addless of person who completed cause of death (Item 23er (Type, Print)
			H. Neal Reynolds, Bon Secours Hospital, 2000 Wast Baltimore
ı	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature
	Registra	ar	JAN 1 6 2004 Received 18 19 19 19 19 19 19 19 19 19 19 19 19 19

			1- For Amend Item	s 12 , 1	State (5,17,18,	of Mar 19a,b,	yland / D 20a,b,c,	epa Cel	irtment of l	dealth Death	and M h	fental Hy	gier Reg. 1	ne_200	+ 00	873
	Dhysiai		1. Decedent's Name (First,	Middle, La	ist)							2. Date of D Month		Day Yee		e of Death
	Physici /Medic		Rober	Go1	iwas							Janua		5, 2004	6:37	PM M
	Examin		4a. Fecility Name (If not ins						4b. City, Town, o		n of Death			c. County of D		
			Anne Arune 5. Social Security Number	-	edical Sex		er In yrs. last birtl	bdaul	Annapo If Under 1 Year		er 24 Hrs.	9 Data of Bi		Anne Ar		A Familia
į,	Funeral Director		213-50-1532		1∭ M 2□F	7. Age (rs.	Months Days	Hours		8. Date of Bi (Month, D July 1	ay, Yea	1950	Birthplace (Sta Country)	unk
	land		Usual Residence of Deceded 10a. State 10b. C	ounty		1	0c. City, Town	or Lo	cation						10d. Inside	City Limits
	Mary -1 eh	ξ	MD An	ne Ai	rundel		Ann	nap	olis						101	′es 2∏No
	r 28a	rec	10e. Street and Number						10f. Zip Code				10g. (Citizen of What	Country?	
	th with	Funeral Director	2700 South	Heav	en Roa	d				21	L401			US	A	
	dea	ner	11. Marital Status		12. Was De Armed F	cedent Eve	er in U.S.	13. V	Vas Decedent of h Yes, specify Cub	Hispanic C	Origin? (Sp	ecity Yes or N Rican, etc.)	0-	14. Race - A Black, W	merican Indian),
21215-0036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hyglene. Important: if Item 27 is marked other then "natural", or Items 23a or 28a-f ehow important: if Item 27 is marked other then "natural", or Items 23a or 28a-f ehow any Injury or other traumatic event, the Medical Examinar must be notified at ance.	þ	1 ♣ Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Div		1 □ Yes If Yes, G Year or	2 (X) No Sive	unk		☐ Yes 2X No	Specif		, ,			white	
200	72 ho	Completed		cedent's E	ducation ade completed	()	16a. I	Deced (Give	lent's Usual Occup	ation	nst of work	ina	16b.	Kind of Busine	ss/Industry	
2	within ene.	npie	Flementary/Secondary (-		(1-4or 5+)			kind of work done OO NOT use retire	d)	Jot of From	y				
7	filed withi Hygiene. other ther		unk 12	<u> </u>	unk			α.	isabled unk	10 14-1	hada Mass	- /5 ^m in-A & 6 int-state		none		1.
land	Mental H Mental H arked ott attic ever	To Be	17. Father's Name (First, M Robert J						unc			e (First, Middle Elaine				- unk
Maryland	12 should h and Men 7 is marks raumatic		19a Informant's Name/Re Robert James (Anne Arunde	ationship	(Type, Print) S-Father	ntor	122	Mailin 64 1	g Address /Street Piney Lane Medica	and Num Remir	ber or Aura	VA 2273	er, City	or Town, State	e, Zip Code)	
	Healt tem 2		20a. Method of Disposition				20b. Place of	Dispo	sition (Name of	1		Date		Location - City)
Baltimore,	permit. Peges 1 and 2 Department of Health a Important: if I tem 27 is any injury or other tra		1 Burial 2 Crem 1 Donation 5 TO	ner (Speci	(y) in st	ate			atory or other pla	(8)	1/22/	/04	Ba1	timore,	MD	
Ba	Depermit Deper Impor any in		21. Sign to a of Funeral S	dicagrica	Wade,	lirec	tor	Gre Ba	Name and Addie mailton 500 Itimore		-	Inc., 2	9 1	ltiwer cderick bre, MD 2	Stree 1728	ŧ
			23a. Part1. Enter the disease shock, or heart failure	se, or con	plications that	caused the	e death. Do no	ot ente	er the mode of dyi	ng, such a	s cardiac	or respiratory a	rrest,	,	Approxir Interval	
	Physician		Immediate Cause (Final disease or condition		. (000	hosic	0	fliver						Onset a	nd Death
Е	/Medical		resulting in death)	-	a. Due to	(or as a c	onsequence of	f):	770						2/	year
	Examiner		Sequentially list conditions		b											
1.	D is	inei	cause. Enter Underlying	1	Due to	OF BE BO	onsequence of	f)c							1	
	and and I-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		c. Due to	o (or as a c	onsequence o	6)-						_	-	
8760,	icate be executed physicien and the burial-transit	a E				7 (01 43 4 0	311354251105 3	.,.								
587		dicai			_ d											
Box	death certific attending p	J/Me	IF FEMALE: 23b. Was decedent pregna	nt	23c. If yes, o			_						23d. Date of	deliverv	
	death certif e attending id for use as	iclaı	in the past 12 months 1 Yes 2 No		4∐Preg	gnant at tim	Fetal death		Ectopic pregnanc Other (specify) _	y				Month	Day	Year
0.	t the by th ache	hys	9 Unknown		9□ Unk	nown										
ds, P	8 50	1 by Physician/M	Part II. Other significant co	nditions	contributing to	death but r	not resulting in	the ur	nderlying cause giv	en in Par	t I.			use contribute		of death?
Ö	w requires been sign should be	etec														
Vital Record	4 CA	Completed												prior t death	autopsy findin o comptetion o? es	of cause of
ta		a	25. Was case referred to n	edical						26. Pla	ce of Deat!	1 Yes		20 101	05	
>	Physicien: this certific ral director.	To B	examiner? 1 🗆 Yes 🔀 No		Hospital:	**************************************	2 🗆 ER/Out	patien	t 3□ DOA Ott	ner: 4 □ 1	Nursing Ho	me 5 Res	dence	6 ☐Other (S	pecify)	
on of	ding Ph. h. After thi funeral	ion:		ending	(Mo	e of Injury onth, Day Y	28b. Ti ear) In	ime of jury	28c. Injui Wo	ry at rk? Yes 2[28d. Describe	how inj	jury occurred		
Division	or Attending after death. Director; After in by the fune	ficat	3 ☐ Suicide 6 ☐	ould not t	oe geo Blac	e of Injury	- At home, far	m. stre	eet, factory, office	103 20		28f. Location	Street	and Number or	Rural Route N	umber
<u>S</u>	i te o	Certification:	4 🗌 Homicide	letermined	build	ding, etc. (Specify)	,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			City or To				
	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	edical (29a. Certifier (Check only one)	rtifying P dical Exa	miner: On the	ne best of n basis of ex nner stated	amination and	death Vor inv	occurred at the tirestigation, in my o	me, date a	and place, eath occurr	and due to the ed at the time,	cause((s) and manner nd place, and d	as stated. ue to the caus	e(s)
	To th within Fo the	Me	29b. Signature and title of	ertifier					29c. Licens					ate signed (Mo	nth, Day, Year	7)
1			1 ful 1	Ko Fo	un	- m	0		D2	480	4		11	106/2	004	
1	(1)		30. Name and address of p	1) .	completed car	use of deat	th (Item 23a) (1	Гуре,	Print) AMC	1	,	1.	111	12/4	151	
			31. Date filed (Month, Day,	9	156 V	1 W	Signature	19	TIME	1	NNO	16121	MC	1011		
¥.	Sta Registr		JAN	1 6 2	004	Sec.	, J.	6	de		ú	/				

			1 - For State Registrar	State of	Marylan		artmen tificate			ind M	ental Hy	/gien Reg. N	60	04	008	74
	Physici /Medi		1. Decedent's Name (First, Middle, Last Helen Har	npson							2. Date of Do Month Januar	су 1	4 20	Year 004	3. Time of De 6:15p	ath M
	Examir	ner	4a. Facility Name (If not institution, give Fairhaven 5. Social Security Number 6. Se		Age (In yrs.	last birthday)		kesv	Location of rille		8 Date of Bi		c. County Car	roll	olaco (Stato or E	io mian
	Funeral Director			M 20 X F	94	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, Di July 2	аў, Уеал 21 1	909	Md	place (State or F ntry)	oreign
	Ba-f show	Director	Md Carroll			y, Town or Lo Sykesv	ille								10d. Inside City I	
	ath with the 23a or 2	ral Dire	7200 Third Avenue					1784		<u>-</u>		USA	itizen of V	Vhat Cou	ntry?	
900	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "neturel", or items 23a or 28a-1 show or other treumatic event, the Madical Examerer must be routified at	d by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Deceded Armed Force 1 Test 2 If Yes, Give Year or Date	es? ∰No	li	Vas Deced f Yes, spec		spanic Orig n, Mexican, Specify:	in? (Spe Puerto I	cify Yes or No Rican, etc.)	0-	Blac	e-Americ k, White, whit		
Maryland 21215-0036	d within 72 h giene. ar than "nett	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12		or 5+)	16a. Deced (Give life I train	kind of wor OO NOT us	k done d e retired)	uring most		9		Cind of Bu		dustry	
yland	2 should be filed vand Mental Hygier Is marked othar freumatic event, It	To Be (17. Father's Name (First, Middle, Last) T. Bennett Charsh						Li11	ian	(First, Middle Thomps	on				
e, Mar	1 and 2 sh Health and em 27 ls m thar treum		John McCann (perso				1awny	Ct.		herv	Route Numb	Md 2	21093		Code)	
Baltimore,	rt. Pa rtmer rtent: njury		1 Department of Disposition 1 Department of Specify) 21. Signature of Funeral Service Licens		a a	emetery, crem raine	Park	her place Cem .	1	-20-	04	Ba1	timo	re,	Md	
Ba	Depa Impo any is		Parge Haight 23a. Part 1. Enter the disease, or complete	Herber	sed the death	P	.O. B	ox 1	95 Sy	kesv	ht Fun ille,	Md 2	. Hom 21784	ie &	Chapel	
	icate be executed //Medical Examiner sthe burial-transit	al Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Hijury	Due to (or	th line.	uence of):									Interval Batwee Onset and Dea	
.O. Box 687	ath certif ittending or use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 20 No 9 □ Unknown		n 2 ∐ Fetal tat time of de	death 3	Ectopic pre Other (spe						23d. Date Mon		ory Day Yea	
rds, P.	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions cor	ntributing to deat	h but not resu	ulting in the un	derlying ca	use giver	n in Part I.		23e. Did t				e cause of deatl	
Vital Records,	The law requ	Completed									24a. Was autor perfo	an osy irmed? 2 No	d	rior to cor eath?	osy findings avai npletion of cause 2 \(\square\) No	iable e of
Division of Vita	Attending Physicien: The lav r death. ector: After this certificate has by the funeral director, page 2	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	lospital: 1 Inp 28a. Date of I (Month,		ER/Outpatient 28b. Time of Injury		Other	. 4Æ Nurs	sing Hom	Check only one 5 Resided.	dence)	
Divisi	i di fie	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of building,	Injury - At ho , etc. (Specify	me, farm, stre	et, factory,				3f. Location (5 City or Tov			or Rura	Route Number,	
/	To the Hospitel within 24 hours a To the Funerel Completely filled	edical	29a. Certifier Check only one) Certifying Physical Examination	sician: To the be ner: On the basis and manner	s of examinat	wledge, death ion and/or inv	occurred a estigation, i	t the time in my opi	, date and nion, death	place, ar occurre	d due to the	cause(s date and	and man d place, ar	nner as stand due to	ated. the cause(s)	
1	To the within 2 To the complet	¥	29b. Signature and title of certifier	te			Do	License				29d. Da	te signed	(Month, L	Day, Year)	
1			30. Name and address of person who co AVA SUCANTE HD72 31. Date filed (Month, Day, Year)	00 Thir	d Ave	, Syke	sull			784						
	Sta Registr		JAN	6 2004	salar s arginat	ure			P							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day William Henry Hill January 15 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carrol1 If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2 □ F 223-26-2942 82 Director VA Nov 15 1921 Usual Residence of Decedent 10a. State 10c. City, Town or Location of Heatth and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other treumatic event, the Medical Examinat must be notified at 10d. Inside City Limits MdCarrol1 Sykesville 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6521 Marvin Avenue 21784 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian 1 Tyes 2 No WWII
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 XNo Specify: Specify: white 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) CR Daniels College (1-4or 5+) textile worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Andrew Jackson Hill Ella Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clara Belle Hill (sister) 6521 Marvin Ave., Sykesville, Md 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Importent: If If any injury or concept of the process. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Sykesville, Md Lake View Memorial *4 □ Donation 5 □ Other (Specify) 1 - 19 - 04permit. 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses Paige Haight P.O. Box 195 Sykesville, Md 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner -transit The law requires that the death certificate be executed physician a the burial-1 Due to (or as a consequence of) Box 68760, Physiclan/Medical use as t IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? res 25 No page 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Mariner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Injury after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dale signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar's Signature 31. Date filed (Month, Day State Registrar

Please	Type or Print in Black Indelible in	C. Ensure All Copies Are Legibi
	Otal of Mandand / Danadasant of	Health and Montal Llugions

KN	•		For State Registrar	State	of Marylar		rtment of F		nd Mental	Hygie Reg.	7111	4 0087	6
			Decedent's Name (First, Middle, L	.ast)					2. Date of	f Death		3. Time of Death	
	Physici		Edward Hackman	Tr.					Month	arv.	Day Yea 12. 2004	M	vi.
	/Medic		4a. Fecility Name (If not institution, o		umber)		4b. City, Town, o	r Location of		ary,	4c. County of De		1.
	Examin	er	St. Agnes Hospi				Baltim	ore			N/A		
				Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 2	4 Hrs. 8. Date o	f Birth	Q F	Birthplace (State or Foreign	n
	Funeral Director		216-50-3013	1 M 2□F	55	Yrs.	Months Days	Hours	Min. (Month	, Day, Ye		Country) Maryland	
E			Usuel Residence of Decedent						indy .	, , , ,	. 7 - 0	riar y rand	
pack	M to		10a. State 10b. County		10c. Ci	ity, Town or Lo	cation					10d. Inside City Limits	
2	Man)	tor	MD N/A				Baltimo	re				XXYes 2 No	ı
4	286	Director	10e. Street and Number				10f. Zip Code			10g.	Citizen of What	Country?	
1	Sa or		1838 Ramsey Str	eet				2122	3		United	States	
90	D8 2	Funeral	11. Marital Status	12. Was De	cedent Ever in U	J.S. 13. V	Was Decedent of H		in? (Specify Yes of Puerto Rican, etc.	_	14. Race - A	ice - American Indian,	
	1 m	ä	1 ☐ Never Married 2 ☐ Married	Armed F	orces?				Puerto Rican, etc	.)	Black, W	hite, etc.	
5	9 7	by	3 ☐ Widowed 4 🖫 Divorced	If Yes, G Year or	ive		1 ☐ Yes 2 XNo	Specity:			Specify:	White	
5 3	ar H	ed	15. Decedent's	Education		16a. Deced	dent's Usual Occup	ation		165	6b. Kind of Business/Industry		
C .	u di	Completed	(Specify only highest of	rade completed		(Give	kind of work done DO NOT use retired	during most d)	of working		,		
7	thar thar	E C	Elementary/Secondary (0-12)	College	(1-4or 5+)	В	ody and F	ender	Repair	A	Automotive		
Maryland 21215-0036	tal Hygiene. Ital Hygiene. d other than *natural; or liems 23a or 28e-f ahow event, the Madical Examiner must be notified at		17. Father's Name (First, Middle, La	st)					's Name (First, Mi				
a a		Be C	Edward Hackman	Sr.				Dor	othy Whit	ahaa	d		
2	s I and 2 should if Health and Men Item 27 is marke other treumatic	ဥ	19a. Informant's Name/Relationship			19b Mailir	ng Address (Street		ror Rural Route N			. Zin Code)	
Z	han han 7 Is u												
o i	leaith leaith om 27 iher tr		Rosa Ammons Date 20a. Method of Disposition	ighter	20b.		West 36t sition (Name of	n Str	eet, Balt				_
Baltimore,	rages nent of H int: If Ite	1 Burial 2 XCremation 3 Removal from State									Oc. Location - City or Town, Stete		
<u>E</u> 3	permit. ragges Department of Important: If it any injury or o		Bayview Crematory, Inc. 1-14-20 21. Signature of Funeral Services and Address of Facility Ambrose										
a	poart poort ny in		21. Signature of Funeral Santa										
0	20 = 20		OWILLIAM !	OUL	MON				ring Rd.,			21227	_
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that	caused the dea	ith. Do not ent	er the mode of dyir	ng, such as o	cardiac or respirato	ry arrest,		Approximate Interval Between	
p	hysician		Immediete Cause (Final			hetru	ctive F	ulmo	nary a	1500	se	Onset and Death	
	/Medical		disease or condition resulting in death)	- u.	o (or as a conse		1_		0	, • •			
E	Examiner		Due to (or as a consequence of).										
45%	#	ē	Suquentially list conditions if any, leading to immediate	b. Due to	o (or as a consec	quence of):						1	
3	nsit en	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
	and al-tra	xai	that initiated events resulting in death) Last	c. Due to	o (or as a conse	quence of):							
8760	rate be executed hysician and the burial-transit												
8	phys the	dlcal	`	d									
×	death certilic e attending pl id for use as t	Physician/Me	IF FEMALE:	23c If yes o	utcome of pregn	ancv					23d. Date of	dalisaas	
Вох	ath	an	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Fet	al death 3	Ectopic pregnancy	у			Month	Day Year	
	0 0 0	sic	1 Yes 2 No	4∐Pre	gnant at time of a nown	death 5L	Other (specify) _						
0 1	ine law requires that me de ite has been signed by the a page 2 should be detached i	F.			double but not co.	aultina in the	ndoskina opusa av	on in Part I	230	Did tobac	co use contribute	to the cause of death?	_
Ś	estr igner	ρλ	Part II. Other significant conditions	s contributing to	death but not re	suiting in the u	nderlying cause giv	rem in Fait i.				Probably 4 Unknown	
ב	w require been sig should b	ted				· · · · · · · · · · · · · · · · · · ·			1 11002	125 185	2 NO 3	Probably 4 Donkhow	
ည် ရ	aw re	ple								Was an autopsy	24b. Were	autopsy findings available to completion of cause of	3
ž į	te has	Completed							1 🗆 Y	performed	? death	? es 2□ No	
Ta i		O	25. Was case referred to medical					26. Place	of Death (Check of				_
5	sice irect	OB	examiner? 15 Yes 2 No	Hospital:	Inpatient 25	ER/Outpatier	nt 3 DOA Off	200	rsing Home 5		e 6 ∏Other /S	necify)	f
Division of Vital Records,	rrthis gral di	To To	27. Manner of Death	28a. Dat	e of Injury	28b. Time o					njury occurred		
0	After the true	ţ	1 Natural 5 Pending 2 Accident investige		onth, Day Year)	Injury		rk? ∣Yes 2.∐N	10				
S	Attending Physician: r death. ector: After this certific by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could no	be 28e. Pla	ce of Injury - At h	home, farm, str	eet, factory, office		28f. Locati	on (Stree	t and Number or	Rural Route Number,	
2	Dire	erti	4 Homicide determine	buil	ding, etc. (Spec	ify)			City o	r Town, S	tate)		
-	To the Hospital or Attending Pro within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 ☐ Certifying	Physician: To 1	he hest of my ko	nowledge death	n occurred at the to	me date and	d place, and due to	the caus	e(s) and manner	as stated	_
4/	Fun Fun fely	edical	(Check only one)	eminer: On the	basis of examin	ation and/or in	vestigation, in my	opinion, deat	h occurred at the t	me, date	and place, and d	lue to the cause(s)	
/	thin the mple	Mec	(Check only one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check one) (Check o										
,	S 7 % -		O.C.M.E. January 13										
	1		tabilla ?										
			30. Name and address of person w					D 7: *		1 -	.a 21201		
			ZABIHU AH	ALI	277		Street,	Balti	imore, Ma	гута	1107 51701	-	
	Sta		31. Date filed (Month, Day, Year)	1 6 200	Registrar Sign	nature	frank.	2					
	Regist	all	JAIN	7 0 400	7	N. S. S.	TOTAL SERVICE						

	1.	For State Registrar	State of Maryla			te of Death	and Me		ene g. No. 20	04	0087
	1.	Decedent's Name (First, Middle, Last	1)				2	. Date of Death			3. Time of Death
sician	Н	ELEANOR			14	DWELLS	j	Month	Day 12 24	Yeer	02:50A
ledical	40	Fecility Name (If not institution, give	street and number)		7	, Town, or Location of	N 1	7.40717-7	4c. County		
aminer		DHNS HOPKINS PRAYVILL		CANGO	1	PLT MIRE					
		Social Security Number 6. Se		rs. last birthday)		r 1 Year If Under:	24 Hrs. 8	. Date of Birth		9. Birtho	place (State or Fore
eral ctor	2		M 25€F 72	Yrs.	Months		Min.	(Month, Day, Jan • 29		Cour	nsylvania
255	-	Da. State 10b. County	10c.	City, Town or Lo	ocation					1	10d. Inside City Limi
or other fraumatic event, the Medical Exams set must be notified at. To Be Completed by Funeral Director	1			,,							1 ☐ Yes 2 🖾 N
Director	N		Ltimore				Rose	edale			
	10	e. Street and Number			10f. Zi	p Code		10	g. Citizen of W	hat Cour	ntry?
alla		6001 Hamilton A	Avenue			2123	37		United	Stat	.es
Funeral	1	I. Marital Status	12. Was Decedent Ever in Armed Forces?	1 U.S. 13.	Was Dece	dent of Hispanic Ori ecity Cuban, Mexican	gin? (Speci	fy Yes or No-		- Americ	can Indian,
2		1 Never Married 2 Married	1 ☐Yes 2 ☑ No				1, 1 00110111	Jan, Gro.)	1		
P P	•	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ∐ Yes	20 No Specify:			Specify:		White
Completed by	-	15. Decedent's Ed	ucation	16a. Dece	adent's Usi	al Occupation		1	6b. Kind of Bu	siness/în	dustry
et	_	(Specify only highest grad	de completed)	(Give	e kind of w DO NOT i	ork done during mos use retired)	t of working				
Ë	1	Elementary/Secondary (0-12)	College (1-4or 5+)	0.	- : 1 m	*****			Steel	Tndii	c+ KI
ပိ		12 Years			oil T		rda Nama /	First, Middle, M			SLLY
Be	. 1	7. Father's Name (First, Middle, Last)							aluen Sumame	")	
ျ		Willard Howel	ils			Kat	theri	ne Ko	nizni		
		9a. Informant's Name/Relationship (T	ype, Print)	19b. Maili	ing Addres	s (Street and Numbe	er or Rural i	Route Number,	City or Town,	State, Zip	Code)
2	N	Mrs. Susan Rinker	(Daughter)	116	5 Cre	ek View Co	ourt	Street	, Maryl	and	21154
	-	Da. Method of Disposition		b. Place of Disp	osition (Na	me of	Da	9 2	Oc. Location - 0	City or To	own, State
5	-	1 🗷 Burial 2 🗀 Cremation 3 🗀	Removal from State	cemetery, cre	-					_	
		`4 ☐ Donation 5 ☐ Other (Specify) <u> </u>			. Park 1/1					Maryland
eny injury pace.	2	1. Signature of Funeral Service Licens	909	2	2. Name a	nd Address of Facilit Ruck Fune:	y ral Ho	ome of	Dundalk	Tn	C
5 a		Vail 11	_			Wise Ave.					
	1 2	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the d	eath. Do not er	nter the mo	de of dying, such as	cardiac or	espiratory arre	st,		Approximate
											Interval Between Onset and Death
an	0	mmediate Cause (Final/ disease or condition	a. AMOXIC B.	RAIN 1	NSVR	/				- 1	8 days
ai		esulting in death)									- 4
er		Constitution line and delines	PLASH PI	VLMONAV	24 E	DEMA					9 days
e e	it o	e uentially list conditions, any, leading to immediate ause. Enter Underlying cause (Disease or injury	Due to (or as a cons	sequence of).						2.1	•
Examiner	Ğ	Cause (Disease or injury nat initiated events									
×	r	esulting in death) Last	Due to (or as a cons	sequence of):							
edicai Examir											
음			, d				-				
0	-										
` ≥	11	F FEMALE:	00. 1/								
an/N	2	3b. Was decedent pregnant	23c. If yes, outcome of pre 1 □ Live birth 2 □ F	etal death 3	□Ectopic p				23d. Date		•
siclan/N	2	3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of	etal death 3	□Ectopic p				23d. Date Mon		ery Day Year
hysician/N	2	3b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ F	etal death 3							•
hysi	2	3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	Fetal death 3 [of death 5 [Other (s	pecify)		23e. Did tob	Mon	ith	•
by Physi		3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	Fetal death 3 [of death 5 [Other (s	pecify)			Mon acco use contri	ith	Day Year
eted by Physi		3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	1 Live birth 2 F 4 Pregnant at time of 9 Unknown	Fetal death 3 [of death 5 [Other (s	pecify)		1 ☐ Ye	Mon acco use contri s 2 □ No	ith ibute to th	Day Year he cause of death? pably 4 2 Unknow
eted by Physi		3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	1 Live birth 2 F 4 Pregnant at time of 9 Unknown	Fetal death 3 [of death 5 [Other (s	pecify)	•	1 Ye	Monacco use contri	ibute to the state of the state	Day Year he cause of death?
eted by		3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	1 Live birth 2 F 4 Pregnant at time of 9 Unknown	Fetal death 3 [of death 5 [Other (s	pecify)		1 Tye	Monacco use contri	ibute to the state of the state	Day Year he cause of death? pably 4 AUnknow
Completed by Physi	_	3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown art II. Other significent conditions of	1 Live birth 2 F 4 Pregnant at time of 9 Unknown	Fetal death 3 [of death 5 [Other (s	cause given in Part I		1 Tye	Monacco use contri s 2 □ No 24b. W p d ed? 1	ibute to the state of the state	Day Year the cause of death? pably 4 AUnknow posy findings availat impletion of cause of
Completed by Physi	2	3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown art II. Other significent conditions of BAVI) STABE ISBN 5. Was case referred to medical examiner?	1 Live birth 2 F 4 Pregnant at time of 9 Unknown ontributing to death but not NAL) (SAASC	Fetal death 3 (of death 5 (Other (s	cause given in Part I	ol Death (1 Ye 24a. Was ar autopsy perform 1 Yes 2 Check only one	Mon acco use contri s 2 □ No 24b. V p ed? d TR No 1	bute to the state of the state	he cause of death? pably 4 (A)Unknow posy findings availate mpletion of cause of
To Be Completed by Physi	2	3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown an II. Other significent conditions of the past 12 M of the pas	1 Dive birth 2 F 4 Pregnant at time of 9 Unknown Ontributing to death but not NAL 1) (SAASC	Fetal death 3 for death 5 for death 5 for death 5 for death 5 for death 5 for death 5 for death 6 for	Other (s	cause given in Part I 26. Place OA Other: 4 No.	ol Death (1 Ye 24a. Was ar autopsy perform 1 Yes 2 Check only one 5 Resider	Monacco use contribution of the contribution o	ibute to the state of the state	he cause of death? pably 4 (A)Unknow posy findings availate mpletion of cause of
To Be Completed by	2	3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown art II. Other significent conditions of the past 12 months? 5. Was case referred to medical examiner? 1 □ Yes 2 ☒ No 7. Manner of Death 1 ☒ Natural 5 □ Pending	1 Live birth 2 F 4 Pregnant at time of 9 Unknown ontributing to death but not VAL 1) (SBASSE Hospital: 1 Q Inpatient 2 28a. Date of Injury (Month, Day Yee)	Fetal death 3 for death 5 for	Other (s	26. Place OA Other: 4 Nu 28c. Injury at Work?	ol Death (ursing Home 28	1 Ye 24a. Was ar autopsy perform 1 Yes 2 Check only one	Monacco use contribution of the contribution o	ibute to the state of the state	he cause of death? pably 4 (A)Unknow posy findings availate mpletion of cause of
tion: To Be Completed by	2	3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown art II. Other significent conditions of the past 12 months? 5. Was case referred to medical examiner? 1 □ Yes 2 ☒ No 7. Manner of Death 1 ☒ Natural 5 □ Pending 2 □ Accident □ investigation	1 Live birth 2 F 4 Pregnant at time of 9 Unknown ontributing to death but not NAL 1) (SMASC Hospital: 1 (A) Inpatient 2 28a. Date of Injury (Month, Day Yeer	Fetal death 3 for death 5 for	Other (s	cause given in Part I 26. Place OA Other: 4 Nu 28c. Injury at Work? 1 Yes 2	o of Death (ursing Home 28	24a. Was ar autops) perform 1 Yes 2 Check only one 5 Resided d. Describe hor	Mon acco use contri s 2 □ No 24b. V p p p p p p p p p p p p p p p p p p p	whith I bute to the state of t	Day Year he cause of death? pably 4 [A]Unknow posy findings availat mpletion of cause of 2 [A] No
To Be Completed by	2	3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown art II. Other significent conditions of BMI) STABE DEFENTING 5. Was case referred to medical examiner? 1□ Yes 2 □ No 7. Manner of Death 1 □ Natural 5 □ Pending	1 Dive birth 2 F4 4 Pregnant at time of 9 Unknown Ontributing to death but not NAL 1) (SAASC Hospital: 1 A Inpatient 2 28a. Date of Injury (Month, Day Yee) 28e. Place of Injury - A	resulting in the control of the cont	Other (s	cause given in Part I 26. Place OA Other: 4 Nu 28c. Injury at Work? 1 Yes 2	o of Death (ursing Home 28	24a. Was ar autops) perform 1 Yes 2 Check only one 5 Resided d. Describe hor	Mon acco use contri s 2 No 24b. V P d R No 1) nce 6 Other w injury occurre	whith I bute to the state of t	he cause of death? pably 4 (A)Unknow posy findings availate mpletion of cause of
tion: To Be Completed by	2	3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown art II. Other significent conditions of the past 12 No 5 Was case referred to medical examiner? 1 Yes 2 No 7. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be	1 Live birth 2 F 4 Pregnant at time of 9 Unknown ontributing to death but not NAL 1) (SMASC Hospital: 1 (A) Inpatient 2 28a. Date of Injury (Month, Day Yeer	resulting in the control of the cont	Other (s	cause given in Part I 26. Place OA Other: 4 Nu 28c. Injury at Work? 1 Yes 2	o of Death (ursing Home 28	1 Ye 24a. Was ar autopsy perform 1 Yes 2 Check only one 5 Thesider d. Describe ho	Mon acco use contri s 2 No 24b. V P d R No 1) nce 6 Other w injury occurre	whith I bute to the state of t	Day Year he cause of death? pably 4 [A]Unknow posy findings availat mpletion of cause of 2 [A] No
Certification: To Be Completed by	2	3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Art III. Other significent conditions or	1 Dive birth 2 F 4 Pregnant at time of 9 Unknown ontributing to death but not NAL 1) (SMASC Hospital: 1 Manatient 2 28a. Date of Injury (Month, Day Yee) 28e. Place of Injury - A building, etc. (Sp. yeician: To the best of my	resulting in the use of the second of the se	Other (s	26. Place 26. Place 27. Other: 4 Nu 28c. Injury at Work? 1 Yes 2 ry, office	o of Death (ursing Home) 28	1 Ye 24a. Was ar autopsy perform 1 Yes 2 Check only one 9 5 Resident d. Describe hor I. Location (Str. City or Town)	Mon acco use contri s 2 □ No 24b. V p dd? CR No 1 1 1) nce 6 □ Othe w injury occurre State)	ibute to the solution of the s	Day Year the cause of death? pably 4 2 Unknown posy findings availate of cause of
tion: To Be Completed by	2	3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Art III. Other significent conditions or	Hospital: 28a. Date of Injury (Month, Day Yee) 28b. Place of Injury - A building, etc. (Sp	resulting in the use of the second of the se	Other (s	26. Place 26. Place 27. Other: 4 Nu 28c. Injury at Work? 1 Yes 2 ry, office	o of Death (ursing Home) 28	1 Ye 24a. Was ar autopsy perform 1 Yes 2 Check only one 9 5 Resident d. Describe hor I. Location (Str. City or Town)	Mon acco use contri s 2 □ No 24b. V p dd? CR No 1 1 1) nce 6 □ Othe w injury occurre State)	ibute to the solution of the s	Day Year the cause of death? pably 4 2 Unknown posy findings availate of cause of
Certification: To Be Completed by	2	3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown art II. Other significent conditions of Art II. Other significant conditions of Art II. Other significent conditions of Art II. Other significant conditions of Art II. Other significant conditions of Art II. Other significant conditions of Art II. Other significant conditions of Art II. Other significant conditions of Art II. Other significant conditions of Art II. Other significant conditions of Art II. Other significant conditions of Art II. Other significant conditions of Art II. Other significant co	1 Dive birth 2 F 4 Pregnant at time of 9 Unknown ontributing to death but not NAL 1) (SMASC Hospital: 1 Manatient 2 28a. Date of Injury (Month, Day Yee) 28e. Place of Injury - A building, etc. (Sp. yeician: To the best of my	resulting in the use of the second of the se	Other (s underlying ent 3 D of M street, facto	26. Place 26. Place 27. Other: 4 Nu 28c. Injury at Work? 1 Yes 2 ry, office	o of Death (ursing Home) 28	1 Ye 24a. Was ar autops) perform 1 Yes 2 Check only one 9 5 Resided d. Describe hor I. Location (Str. City or Town.) d due to the call at the time, da	Mon acco use contri s 2 □ No 24b. W p d (ed? R No 1 b) nce 6 □ Othe w injury occurre eet and Number State) use(s) and mar te and place, a	bute to the source of the sour	Day Year the cause of death? pably 4 [A]Unknow posy findings availat impletion of cause of 2 [A] No fy) al Route Number, stated. to the cause(s)
tion: To Be Completed by	2	3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown art II. Other significent conditions of Art III. Other significant conditions of Art III. Other significant conditions of Art III. Other significant conditions of Art III. Other significant conditions of Art III. Other significant conditions of Art III. Other significant conditions of Art III. Other significant conditions of Art III. Other significant conditions of Art III. Other significant conditions of Art III. Other significant con	1 Dive birth 2 F 4 Pregnant at time of 9 Unknown ontributing to death but not NAL 1) (SMASC Hospital: 1 (Anpatient 2) 28a. Date of Injury (Month, Day Yeel 28b. Place of Injury - A building, etc. (Sp. ysician: To the best of my niner: On the basis of exam and manner stated.	resulting in the use of the second of the se	Other (s underlying ent 3 D of M street, facto	26. Place OA Other: 4 Nt. 28c. Injury at Work? 1 Yes 2 Try, office d at the time, date ann, in my opinion, dea	o ol Death (ursing Home) 28 No 28 no deplace, and the occurred	1 Ye 24a. Was ar autops, perform 1 Yes 2 Check only one 9 5 Resided d. Describe hor I. Location (Str. City or Town.) d due to the call at the time, da	Mon acco use contri s 2 □ No 24b. W P d R No 1 1 Other winjury occurre winjury occurre winjury occurre use(s) and mar te and place, a dd. Date signed	bute to the source of the sour	Day Year the cause of death? pably 4 [A]Unknow posy findings availat impletion of cause of 2 [A] No fy) al Route Number, stated. to the cause(s) Dey, Year)
Certification: To Be Completed by Physi	2	3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown art II. Other significent conditions of Art II. Other significant conditions of Art II. Other significent conditions of Art II. Other significant conditions of Art II. Other significant conditions of Art II. Other significant conditions of Art II. Other significant conditions of Art II. Other significant conditions of Art II. Other significant conditions of Art II. Other significant conditions of Art II. Other significant conditions of Art II. Other significant conditions of Art II. Other significant co	1 Dive birth 2 F 4 Pregnant at time of 9 Unknown ontributing to death but not NAL 1) (SMASC Hospital: 1 (Anpatient 2) 28a. Date of Injury (Month, Day Yeel 28b. Place of Injury - A building, etc. (Sp. ysician: To the best of my niner: On the basis of exam and manner stated.	resulting in the use of the second of the se	Other (s underlying ent 3 D of M street, facto	26. Place OA Other: 4 Nt. 28c. Injury at Work? 1 Yes 2 ry, office	o ol Death (ursing Home) 28 No 28 no deplace, and the occurred	1 Ye 24a. Was ar autops, perform 1 Yes 2 Check only one 9 5 Resided d. Describe hor I. Location (Str. City or Town.) d due to the call at the time, da	Mon acco use contri s 2 □ No 24b. W p d (ed? R No 1 b) nce 6 □ Othe w injury occurre eet and Number State) use(s) and mar te and place, a	bute to the source of the sour	Day Year the cause of death? pably 4 [A]Unknow posy findings availat impletion of cause of 2 [A] No fy) al Route Number, stated. to the cause(s) Dey, Year)
ilon: To Be Completed by Physi	2	3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown art II. Other significent conditions of Art II. Other significant conditions of Art II. Other significent conditions of Art II. Other significant conditions of Art II. Other significant conditions of Art II. Other significant conditions of Art II. Other significant conditions of Art II. Other significant conditions of Art II. Other significant conditions of Art II. Other significant conditions of Art II. Other significant conditions of Art II. Other significant conditions of Art II. Other significant co	Hospital: 1 (A) Inpatient 2 28a. Date of Injury (Month, Day Yee) 28b. Place of Injury (Month, Day Yee) 28c. Place of Injury (Month, Day Yee)	resulting in the use of the second of the se	Other (s underlying ent 3 D of M street, factor extreet, facto	26. Place OA Other: 4 Nu 28c. Injury at Work? 1 Yes 2 Injury office d at the time, date ann, in my opinion, dea	o ol Death (ursing Homursing Homursing 28 No 28 nd place, and th occurred	24a. Was ar autops) perform 1 Yes 2 Check only one 9 5 Resided d. Describe hor City or Town.	Mon acco use contri s 2 No 24b. W led? d d IR No 1 Other w injury occurre state) use(s) and mar te and place, a and Date signed ANN ARY	ibute to the solution of the s	Day Year the cause of death? pably 4 [A]Unknow posy findings availat impletion of cause of 2 [A] No fy) al Route Number, stated. to the cause(s) Dey, Year)
ilon: To Be Completed by Physi	2 2 2	13b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1	Hospital: 1 A inpatient 2 28e. Place of Injury (Month, Day Yeer building, etc. (Sp	resulting in the use of the second of the se	Other (s underlying ent 3 D of M street, factor extreet, facto	26. Place OA Other: 4 Nu 28c. Injury at Work? 1 Yes 2 Injury office d at the time, date ann, in my opinion, dea	o ol Death (ursing Homursing Homursing 28 No 28 nd place, and th occurred	24a. Was ar autops) perform 1 Yes 2 Check only one 9 5 Resided d. Describe hor City or Town.	Mon acco use contri s 2 No 24b. W led? d d IR No 1 Other w injury occurre state) use(s) and mar te and place, a and Date signed ANN ARY	ibute to the solution of the s	Day Year the cause of death? pably 4 [A]Unknow posy findings availat impletion of cause of 2 [A] No fy) al Route Number, stated. to the cause(s) Dey, Year)

			1 - For State Registrar	State of	Marylar	nd / Depa	artmer rtificat	nt of H te of L	ealth a Death	nd Mo	ental Hy	giene Reg. No.	2001	+ 0087	78
	Physici	an	1. Decedent's Name (First, Middle, La		10						2. Date of De Month	ath Day	/ Year	3. Time of Death	
	/Medic	al	4a. Facility Name (If not institution, given	HLOB	-		Ah Cih	Town or	Location of	f Death	01/	14	County of Dea	7	M
	Examin	er	4a. Facility Name (in not institution, give	MARIT	MANG	HODPINAL	40. City	34	CF (DRE	70.	BA	CTIMOR	E
	Funeral		5. Social Security Number 6. 5	Sex 7		last birthday)		r 1 Year Days	If Under 2	24 Hrs. Min.	8. Date of Bir (Month, Da	rth	9. Bir	thplace (State or Fore	əign
H	Director			1□M 2∏F	84	Yrs.	MOTITIES	Days	riouis		1arch 21	, 1919	Peñi	nsylvania	
П	and		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Lim	nits
	the Marylan 28a-f show	ξ	Maryland N/A			Baltimo	re							1 Yes 2 □ 1	No
	h the	iec	10e. Street and Number				10f. Zi	p Code				10g. Citiz	en of What Co	ountry?	
	23a c	Funeral Director	3717 Bayonne Avenue					21206					USA		
	er deg	n ne	11. Marital Status	12. Was Deced	es?	J.S. 13.	Was Dece If Yes, spe	dent of Hi ocify Cuba	spanic Orig n, Mexican,	jin? (Spec , Puerto F	cify Yes or No Rican, etc.)	o- 1	 Race - Ame Black, White 		
36	Irs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Tes 2 If Yes, Give Year or Dat	′`		1 ☐ Yes	2 💢 No	Specify:				Specify: Whi	ite	
Š	filed within 72 hours after death with the Maryland Hydione. ther than "natural", or items 23a or 28a-f show int, the Madical Extractiver coust be notified at	ted	15. Decedent's E	ducation		16a. Dece	dent's Usu	al Occupa	ition	of workin		16b. Kin	d of Business	/Industry	
21215-0036	ithin 7	Completed	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4	for 5+)		<i>po voti</i> e Mana		luring most)	OI WOIKIII	g		`onetra let	tion/Contract	+i n
2	filed with Hygiene ther the		12 17. Father's Name (First, Middle, Last	1		OTTIC	e nanc	iger	18 Mother	r's Name	(First, Middle			tion/Contract	-111
Maryland	ntal h) Be	Joseph Hlobick	/					Marya			, Maideri C	ourname)		
Ž	2 should be fitled withir and Mental Hygiene. Is marked other than aumatic event, the M	ဥ	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Addres	s (Street a				er, City or	Town, State,	Zip Code)	
	1 and 2 Health a lem 27 Is		Elizabeth P. Genovese	/Sister		1307	Brixt	ton Ro	ad Bal	ltimor	e Maryl	and 2	1239		
ore,	of Her of Her fitem r othe		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 [Bemoval from Si	ate	Place of Dispo cemetery, crea	natory or	other plac			ate	20c. Loc	ation - City or	Town, State	
Ĕ	Pages ment of the		* 4 □Donation 5 □ Other (Speci	<i>(y)</i>	НО	ly Trini)4	E1	kridge N	Maryland	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Menial Hygiene. Department of Heath and Menial Hygiene. The proportant: If item 27 Is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Muclical Exterilizational page. Once.		21. Signature of Funeral Service Licensee Christina L. Hilton 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 23a. Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,												
8760,	Physician /Medical Examiner the prival-transit	cal Examiner	Shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):											Onset and Death	
P.O. Box 68	the death certific by the attending p ached for use as	1 live birth 2 Estados organizados									3d. Date of de Month	livery Day Year			
	w requires that s been signed t should be deta	ğ	Part II. Other significent conditions		ith but not res	sulting in the u	nderlying	cause give	en in Part I.			tobacco us Yes 2 □	A	o the cause of death? robably 4 ⊟Unknow	
Sor	v requ	ete									24a. Was	an	24h Were a	itoosy findings availat	ble
of Vital Records,	sician: The law s certificate has b lirector, page 2 s	Completed								_	auto	psy ormed? 2 No	prior to death?	utopsy findings availat completion of cause of	of
/ita	cian: ertific ector,	Be	25. Was case referred to medical examiner?					011		of Death	(Check only	one)			
ot \	Physi this c al dire	. To	1 ☐ Yes 2 ☐ ₩0	Hospital: 1 1 Im		ER/Outpatier			4 🗆 Nur		e 5 Resi		Other (Spe	cify)	
uo	ding F h. After funer	tlon	V Natural 5 Pending 2 Accident investigation	28a. Date of (Month	Day Year)	Injury	м	28c. Injury Work	(? Yes 2 □ N		ou. Doscribe	now inquiry	occurred		
Division	To the Hospital or Attending Physician: The I within 24 hours after dash. To the Funeral Director: After this certificate hat completely filled in by the tuneral director, page	Certification;	3 Suicide 6 Could not lead to determine determined	28e. Place o	f Injury - At h g, etc. (Speci	nome, farm, str fy)	reet, factor	ry, office		2	8f. Location (City or To	Street and wn, State)	Number or R	ural Route Number,	
	e Hospit, 24 hours e Funera etely fille	Medical C		hysicien: To the b miner: On the bas and manne	is of examina										
	To the within To the	Me	29b. Signature and title of certifier					c. License				29d. Date	signed (Mont	h, Day, Year)	
	1		1. C. Mana	> MI				Doc	606	587	2	10	114/	2004	
	5		30. Name and address of person who	completed cause		m 23a) (Type,	Print)	CF	ME	921	man		DI PITI		
	Sta	ate	31. Date filed (Month, Day, Year)	32 Re	gistrar's Sign			7.		, , _ ,	, 0	/ (- / - / *	1	
	Registr		IAN 1 6 20	04 /2	una d	1. 1300	seles s								

		1 - For State Registrar		aryland / De _l	ertificate					leg. No. 2	104	0087
Physici	an.	1. Decedent's Name (First, Middle, La	st)					1	2. Date of Dea	th Day	Yeer.	3. Time of Death
/Medic		Mark		Т.			don		January	12,2	004	6:51 PM
Examin	er	4a. Facility Name (If not institution, giv		1	1		Location of	f Death	0	4c. Count	of Death	
Emand		Union Memorial 5. Social Security Number 6. S		l 1 le (In yrs. last birthda	Balt v) If Under		If Under 2	24 Hrs.	B. Date of Birth	NA	9 Birthr	olece (State or Foreign
Funeral Director			MM 2□F	43 Yrs.	Months	Days	Hours	Min.	B. Date of Birth (Month, Day	, Year) 60	Coul	MD
2		Usual Residence of Decedent							. 2 00	- 00		
72 hours after death with the Maryland natural', or items 23s or 28s-f show acel Exeminar must be notified at	_	10a. State 10b. County		10c. City, Town or							1	Od. Inside City Limits
28a-f	ecto	MD NA 10e. Street and Number		Baltimo		0.1.				0.00		XXes 2□No
jiene. r than "natural", or flems 23s or 28s-f show the Medical Exertine roust be rediffed at	Funeral Director		_		10f. Zip		_			l0g. Citizen of		ntry ?
ns 23	era	2422 North Cha	rles Str		3. Was Deced	212		in? (Spec	fv Yes or No-	14. Rac	B - Americ	an Indian.
ritie	Fur	1X Never Married 2 ☐ Married	Armed Forces?	No				Puerto R	fy Yes or No- ican, etc.)	Bla	ck, White,	
Exal.	l by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2	2LXNo	Specify:			Specif	v: В.	lack
natu	Completed	15. Decedent's Ed (Specify only highest gra	ducation de completed)	16a. Dec (Git	edent's Usua	al Occupa rk done d	ition uring most	of working	,	16b. Kind of B	usiness/In	dustry
than "	mpi	Elementary/Secondary (0-12)	Cotlege (1-4or 5	5+)	. DO NOT us						_	
Hygiene. other than		12th grade 17. Father's Name (First, Middle, Last)	na		Press			's Name /		United Meiden Suman		ok Press
d d	Ö	Robert T. Jordo							. Pri		107	
ih and Mer 7 is marke traumatic	2	19a. Informant's Name/Relationship (19b. Ma	iting Address					**	State. Zip	Code)21218
alth a 27 is r trau		Robert T. Jord	lon-Broth									Balto, M
of Health fitem 27 r other tr		20a. Method of Disposition		20b. Place of Dis		ne of		Da		20c. Location		
nent or int: If		1 ☐ Burial 2 ☐ Fremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specification)	Removal from State /)	Metro	-	3	1	-16	-04	Altin	VORP !	mil
Department important: If any injury or once.	Ì	21. Signature of Funeral Service Licen	fee /		22. Name and	d Address	Facility				1000	11. 12.
8 = 3		Blyma ?	5-15e	ke 2	March 1300 W	r/n Naba	wes sh A	ve.	Balti	more N	1d 2	21215
R.		23a. Part . Enter the disease, or com- shock, or heart failure. List only	olications that caused one cause on each li	the death. Do not e	nter the mode	e of dying	, such as c	ardiac or	espiratory arr	est,		Approximate Interval Between
sician		Immediate Cause (Final disease or condition	· Pulin	DHARY	SW	1 60	luc					Onset and Death
ledical aminer		resulting in death)	Due to (or as	a consequence of):		1 0 0	140					
100	_	Sequentially list conditions,	b. Can									10 YEARS
sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):								
and II-trar	xan	that initiated events resulting in death) Last	c. Due to (or as	a consequence of);								
hysician and ihe burial-transit	ā		-									
phy:	edic		d									
attending phy I for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		- ·					23d. Da	e of delive	ry
ned by the atter	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at		☐Ectopic pre☐ Other (spe					Мо	nth	Day Year
by th	hys	9 Unknown	9□ Unknown									
signed to	by F	Part II. Other significant conditions of	ontributing to death be	ut not resulting in the	underlying ca	ause giver	n in Part I.				ribute to th	e cause of death?
been si should								_	1) XY 6	s 2 No	3 🔲 Prob	ably 4 □Unknown
SO	Completed							_	24a. Was a		Vere autop	osy findings available
ate	5								perform	ned?	leath?	2. NO
certificate rector, pag	Be	25. Was case referred to medical examiner?	Harada (_		of Death (Check only on	9)		
	၉	1 192 5140	Hospital: 1 Inpatie			-	4 Nurs	sing Home	-	nce 6 Oth)
After funer	on	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injui (Month, Da)			Bc. Injury	?		d. Describe ho	w injury occurr	ed	
death ctor: / the	Certification:	2 Accident investigation 3 Suicide 6 Could not be		ury - At home, farm, s	M treet factors		es 2 □ N		Location (St	mot and Numb	or or Over	Route Number,
after Dira Jin by	ertii	4 ☐ Homicide determined	building, etc	c. (Specify)	treet, ractory,	, onice		201	City or Town	, State)	ar or Hurai	Houte Number,
within 24 hours after death. To the Funerel Diractor: After this completely filled in by the funeral di		29a. Certifier Certifying Ph	ysician: To the best of	of my knowledge, dea	ath occurred a	at the time	e, date and	place, and	d due to the ca	use/s) and ma	nner as st	ated
24 h	edicai	(Check only 2 Medical Exaπ	iner: On the basis of and manner sta	examination and/or i	nvestigation,	in my opi	nion, death	occurred	at the time, da	ite and place, a	ind due to	the cause(s)
withir To th comp		29b. Signature and title of centiler			29c.	License	number		29	d. Date signed	(Month, L	Day, Year)
- 1		Dialue /	Linasan Mi	O Attentino	. 0	100	546	48		Januar	y 12	2004
1		TI X I VIN	A MAN ISMIT HALL				inst J Mari	1 /3		WILLIAM WOLL	7 1 %	a 1 - 1
3		30. Name and threst of person who	completed cause of de	eath (Item 23a) (Type	a, Print)	0 0		* 15				
3		30. Name and Names of Person who of the Mount of State (Month, Day, Year)	MABRER.	eath (Item 23a) (Type MP 20 (ar's Signature	e, Print)	VELS	b 8	lar Ku	~ ()	ballino	ie W	1. 21218

		•	For State Registrar	Sta	te of M	aryland /		artment of H rtificate of I			jiene _{leg. No.} 20	104	00880
H	Physicia /Medic		1. Decedent's Name (First, Middle	e, Last)	Cecil	ia C. i	Jord	an		2. Date of Dea Month January	Day	Year 04	3. Time of Death 6:15 A ^M
	Examin		4a. Facility Name (If not institution	_					Location of Death		4c. County		_
			Genesis Loch 5. Social Security Number	Raven (e (In yrs. last	birthday)	Loch	Raven	8. Date of Birth			ore Co.
	Funeral Director		218-18-5957	1 □ M 2	e c	8	Yrs.	Months Days	Hours Min.	(Month, Day	, Year)		place (State or Foreign htry) Cyland
	land ow	-	Usual Residence of Decedent 10a. State 10b. County			10c. City, To	own or Lo	ocation				1	0d. Inside City Limits
	a-f sh	ctor	Maryland Bal	timore				M	iddle Riv				1 ☐ Yes 2€ No
	or 28	Director	10e. Street and Number					10f. Zip Code			10g. Citizen of V		-
	s 23s		15 Maxa Court	12 14/	ne Dogodoni	Ever in U.S.	13	Was Decedent of H	21220	necify Yes or No-	Unite		ates can Indian,
30	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event. In a Medical Examiner must be notified at	by Funerai	11. Marital Status 1 Never Married 2 Mar XXWidowed 4 Divorced	ried 1 [med Forces? Yes 240x es, Give ar or Dates:			Was Decedent of H If Yes, specify Cuba 1 ☐ Yes ※XX No	Specify:	Rican, etc.)	Specify	ck, White,	
2-003e	2 hou		15. Deceder	it's Education	oleted)	10	5a. Dece	dent's Usual Occup	ation	kina	16b. Kind of Bu	usiness/ln	dustry
7	vithin 7 ne. han "n	Completed	(Specify only higher	-	llege (1-4or	5+)		kind of work done of DO NOT use retired		Ning	Elect	roni	c Industry
V	filed Hygi ther ent.		12 Years 17. Father's Name (First, Middle,	Last)		-		дыскыту	18. Mother's Nam	ne (First, Middle,			2110425-1
yland	lid be fental rked o	To Be	Julius Czorap	inski				į	Frances	s Rutkow	ski		
Mary	and N		19a. Informant's Name/Relations Daniel Grossni					ng Address (Street Maxa Cour		ral Route Numbe e River,			Code) 21220
saltimore,	Pages 1 and 3 nent of Health int: if item 27 iry or other tru		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		al from State	ceme	tery, cre	osition (Name of matory or other place islaus Ce		Date 1/15/200	20c. Location - 4 Dun		own, State , Maryland
Balti	permit. Pages Department of I Important: If ite any injury or o'	y 1	21. Signature of Funeral Service	Licensee	aul	0		Duda-Ruck 7922 Wise					nc. 1222
	Pnysician /Medical		23a. Part 1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	a	en	d the death. Cine.	o not en						Approximate Interval Between Onset and Death
	Examiner	L.	Sequentially list conditions, if any, leading to immediate	b. —		a consequen							/
	outed Id ansit	Examiner	Cause (Disease or injury that initiated events	S									
8760,	cate be executed physician and the burial-transit	dical Exa	resulting in death) Last	d	Due to (or as	a consequen	ce of):						
O. Box 68	The law requires that the death certifics ate has been signed by the attending pt page 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past (2 months? 1 □ Yes 25 No 9 □ Unknown	1(Live birth	e of pregnancy 2 Fetal de at time of death	ath 3[□Ectopic pregnancy □ Other (specify) _	у			te of delive	ery Day Year
ď	ires that the signed by	by	Part II. Other significant condit	ions contribut	ing to death	but not resultin	ig in the t	anderlying cause giv	ven in Part 1		bacco use cont	nbute to t	he cause of death?
corc	aw requi s been s 2 should	Completed	Coymadi	n TY	00000	Z	-	courses of	- Comme	24a. Was autop	an 24b.	Were auto	ppsy findings available impletion of cause of
H.	The la	Com						-		perfor	med?	death? 1 🗌 Yes	2 No
lita	cian: ertifica ector,	Be (25. Was case referred to medicinexaminer?		-li			O#		th (Check only o			
of	Physic this c	5	1 ☐ Yes 2 No 27. Manner of Death	Hospita	al: 1 ☐ fnpat a. Date of fnj		Outpatie	nt 3 DOA	Nursing H	ome 5 Resid			y)
ion	nding lath.	ation	1 Natural 5 ☐ Pend		(Month, D	ay Year)	Injury	Wo	rk? Yes 2 □ No		over in query cooks.		
Division of Vital Records,	il or Attendi after death. I Director: A d in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homacide deten	not be mined 28	e. Place of fr building, e	njury - At home atc. (Specify)	, farm, st	reet, factory, office		28f. Location (S City or Tow		er or Rura	al Route Number,
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical C		I Examiner: C		of examination		th occurred at the travestigation, in my o					
	To th within To th comp	Me	29b. Signature and title of certifi	er		654		29c. Licens	se number		29d. Date signe	d (Month,	Day, Year)
)			Miller	C. All	While	mas		1053	15/18		1/ 12	104	la de la companya de la companya de la companya de la companya de la companya de la companya de la companya de
	7		30. Name and address of person	who comple	sed cause of	death (Item 23	a) (Type	Print)	balton	1 Mn 2.	1237		
61	Sta		31. Date filed (Month, Day, Yea		32. Regis	trar's Signature	-1/VC1 B	1 404161	v v v v i v s 6 v				
	Regist	rar	JAN 1 6	2004	A BANK	a Me	Short .	300					

		1 - For State Registrar	State of Maryla	nd / Depa		Health and		ne 2001	. 00881	
Phys /Me Exan	dical	Decedent's Name (First, Middle, Last) Lucille Joh 4a. Facility Name (If not institution, give s	treet and number) S. HEALTH		BAL	or Location of Deat	2. Date of Death Month Correction	Day Year 7 , 200 4c. County of Dea	4 1+03 M	
Funera Directo		220-70-7007	7. Age (In yr.	s. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, You Sept 4,	9. Bir 1923	thplace (State or Foreign ountry) unk	
he Maryland 8a-f show	Director	Usual Residence of Decedent 10a. State 10b. County MD	10c. C	Balti	imore				10d. Inside City Limits 1√2 Yes 2 □ No	
th with ti 23a or 2 mil by th	al Dire	10e. Street and Number 3330 Wilkens Ave	nue		10f. Zip Code	.229	10g.	USA	ountry?	
hours after death with the Marylar hours after death with the Marylar turel', or Items 23e or 28e-1 show	by Funeral	11. Marital Status UNK 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	unk	Was Decedent of If Yes, specify Cub 1 ☐ Yes 2X No	Hispanic Origin? (Span, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specify:		
VIGITION AT IN 13-00300 United by filed within 72 hours after death with the Maryland Mental Hygiene. Third other than "naturel" or items 23a or 28a-f show tife event, the Medical Exercities must be recitified at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of wo	tking unk 16t	D. Kind of Business	/Industry unk	
ed is b	To Be Co	17. Father's Name (First, Middle, Last)	K		unk	18. Mother's Nar	ne (First, Middle, Mai	den Sumame)	unk	
ges 1 and 2 should t of Health and Mer If item 27 is marks or other traumatic		19a. Informant's Name/Relationship (Type St. Agnes Healtho					ral Route Number, Co Baltimore		Zip Code) 229	
Definition of your properties of an apportant: If item any injury or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 🛣 Other (Specify)	20b.	Place of Dispo	sition (Name of matory or other pla			: Location - City or		
permit. Pag Department Important: any injury	- Succe	21. Signature Funeral True Sicense	ate Virecto	r St Ba	Name and Address ate Anat altimore,	ess of Facility Comy Boar MD 2120	₁ 655 W. в	altimore	Street	
Physicia /Medica		23a. Part1. Exter the disease, or complications shock, onheart failure. List only on Immediate Cause (Final disease or condition resulting in death)	PNE	EUMO		ng, such as cardiad	or respiratory arrest,		Approximate Interval Between Onset and Death	
Examine		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Due to (or as a consequence of): SEPSIS' SYNDROME Due to (or as a consequence of): RENAL FAILURE								
le be executed ysician and e burial-transit	cal Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse		FAILU	KE.			Traugs	
death certifical e attending phy dor use as th	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregr 1 Live birth 2 Fer 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pregnanc	у		23d. Date of del Month	ivery Day Year	
requires that the	b	Part II. Other significant conditions conf	nbuting to death but not re	sulting in the ur	nderlying cause gr	ven in Part I.		_/	the cause of death?	
ician: The law requires certificate has been sign ector, page 2 should be	Completed						24a. Was an autopsy performed 1 Yes 2 D	? prior to death?	itopsy findings available completion of cause of 2 No	
Phys rat dii	tion: To Be	25. Was case referred to medical examiner? 1 □ Yes 2 □ No Ho 27. Manner of Death 1 ☑ Natural 5 □ Pending 2 □ Accident investigation	spital: 1 Inpatient 2[28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Inju	ner: 4 ☐ Nursing H ry at	th (Check only one) ome 5 Residence 28d. Describe how in		orfy)	
s after death. The control of the c	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, stre ify)	eet, factory, office		28f. Location (Street City or Town, St	and Number or Ru ate)	ral Route Number,	
e Hospi 24 hour e Funera etely fille	edical (29a. Certifier 1 Certifying Physic (Check only one)	cian: To the best of my kn er: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred at the time stigation, in my control	me, date and place opinion, death occu	and due to the cause rred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)	
To th within To the	Me	29b. Signature and title of certified	of .		29c. Licens	59598	29d.	Date signed (Month	, Day, Year)	
		30. Name and address of person who con	opleted cause of death (Ite	m 23a) (Type, I	CATO,	N AVE	NUE, E	BALTMO	RE, MD-21229	
S Regis	itate strar	31. Date filed (Month, Day, Year)	32 Registrar's Sign	ature	enter)					

JOHNSON,

State of Maryland / Department of Health and Mental Hygiene

			State of h		ertificate of Death	ina moman ny	Reg. No. 2001	4 00882
	Physic	ian	1. Decedent's Name (First, Middle, Last)			2. Date of De Month	Dey Year	3. Time of Death
W. Y	/Medi	cal	4a Fecility Name (If not institution, give street and number	r)	4b. City. Tow	n, or Location of Deet	13 04 h 4c. County of Dea	11:30 PM
T	Exami	ner	Marine Capo - Par	Jour	TOU	14020	Baltiv	MORO
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 S. F Usual Residence of Decedent	Age (In yrs. lest birthday) If Under 1 Year If Under 2 Months Deys Hours	HA Hrs. 8. Date of Bin (Month, Date of Bin (Month, Date of Bin (Month))	th 9. Bir ly, Year) 9. Bir 1909 Mu	rthplace (State or Foreign Jountry)
	ylend how		10a. Stete 10b. County	10c. City, Town or L	ocation	/		10d. Inside City Limits
	Ba-f s	ector	MD Baltmore	Parkvi	ILE			1 ☐ Yes 2 No
	ath with ti	Funeral Director	2610 Burridge Rd		10f. Zip Code 2/234		10g. Citizen of What C	
020	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylend Depertment of Health end Mental Hyglene. Important: if item 27 is marked other than "natural", or itams 23a or 28a-f show simportant: if item 27 is marked other than "natural" or itams 23a or 28a-f show hy injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Deceder Armed Forces 1 □ Yes, Give Year or Detes	⊉No	Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican, 1 ☐ Yes 2 ☑ No Specify:	in? (Specify Yes or No Puerto Rican, etc.)	14. Race - Ame Black, Whi	
21215-0020	within 72 h ene. than "natu he Medica	Completed by	15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4o	(Give	edent's Usual Occupation e kind of work done during most DO NOT use retired)	of working	Montgon	eley Wards
Maryland 2	ould be filed with Mental Hygiene. arked other than etic event, Item	Be	17. Father's Name (First, Middle, Last)	Δ	18. Mother	's Name (First, Middle	, Maiden Surname)	2
ary	2 should end Men is marke	70	19a. Informant's Name/Relationship (Type, Print)	19b. Mai	ing Address (Street and Number	or Rurel Route Numb	er, City or Town, State,	Zip Code)
	1 end 2 Health e em 27 is		Ellen Link-daughter	2 261C	Bulkidge Rd	Balting	DRE MD à	11234
Baltimore,	Pages 1 ment of H ant: if Ite ury or ot		20a. Method of Disposition 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removal from Stat 4 ☐ Donation 5 ☐ Other (Specify)	e PORKUO	omatory or other place)	Jan 17 2004	Pophillo	Town, State
Balt	permit. Pag Depertment Important: it any injury o		21. Signature of Funeral Service Licensee		2. Name and Address of Facility	EVAND F	UKORAL CH	afel ND 21234
	à°		23. Part1. Enter the disease, or complications that causishock, or heart failure. List only one cause on each	ed the death. Do not en	nter the mode of dying, such as c	erdiac or respiratory a	rrest,	Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	diomy.				Onset and Death
	pe tis	iner	b,					î 1
60,	rifficete be executed ng physician end s es the buriel-trensit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c	Due to (or as a conse	quence of):			
x 68760,	ding physise es the l	Medicai	that initieted events resulting in death) Last	Due to (or as a conse-	quence of):			
Box	death ce ettendir d for use	ician	Part Ii. Other significant conditions contributing to death	but not resulting in the	underlying gauss given in Part I	23h Did	tohacco una contribute	e to the cause of death?
P.O.	thet the death cer ned by the ettendir e deteched for use	Physician/	ratti. Otter signincant conditiona contibuting to death	but not resulting in the t	anderlying cause given in Part I.			Probably 4 Unknown
of Vital Records,	aw requires ss been sign 2 should be	Completed by				24a. Was	med?	Were autopsy findings available prior to completion of cause of death?
al R						101	Yes ENNO	1 ☐ Yes 2 ☐ No
Ziti	Physician: The this certificate ral director, page	o Be	25. Was case referred to medical examiner? 1 Yes 22 No Hospital: 1 Inpat	ient 2 ER/Outpatie	Other	of Death (Check only o		-4.1
0 ر	5 E 8	n: To	27. Manner of Death 1. ■Natural 5 □ Pending (Month, D				dence 6 □Other (Spe how injury occurred	(cify)
Division	To the Hospital or Attending F within 24 hours efter death. To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Ir	njury - At home, farm, st	M 1 Yes 2 N		Street and Number or Ri	ural Route Number,
	urs efte							
V	To the Hospital within 24 hours of To the Funeral completely filled	Medical	29a. Certifier (Check only one) Certifying Physician: To the besise and manners	of examination end/or in	th occurred at the time, date end exestigation, in my opinion, death	place, and due to the occurred at the time,	cause(s) and manner as date and place, and due	s stated. e to the cause(s)
	To the Comple	M	29b. Signature and title of certifier		29c. License number	2 //	29d. Date signed (Mont	
	1 ~		I'm fel	e D.0	H005440	14	1-14-0	4
			30. Name and address of person who completed cause of	deeth (Item 23e) (Type,	Print) Suite 205 Tou	Json, MI)	21204	
1484	Sta	196	31. Date filed (Month, Dey, Year) 32. Regist	trer's Signature	de de la companya della companya del			
, i	Registr	ar	ian 1 6 200	Missin L	A ANDRES			

			1 - For State Registrar	State of Maryland	•	artment of H rtificate of L		-	giene Reg. No. 20 (00883				
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Gladys Thomps					2. Date of De Month Januar	y 13 2004					
P. C.	Examin		4a. Facility Name (If not institution, give st Fairhaven				sville		4c. County of Carrol					
	Funeral Director		5. Social Security Number 6. Sex 278-42-8176	7. Age (In yrs. li M 2□XF 97	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hi Hours Mii	8. Date of Birth (Month, Da April	^h , Year) 1906	Birthplace (State or Foreign Country) LOWA				
	Maryland -f show lied at	tor	10a. State 10b. County Md Carrol1		Town or Lo					10d. Inside City Limits 1 X Yes 2 □ No				
	h with the 23e or 28e st be noti	ai Director	10e. Street and Number 7200 Third Avenue			10f. Zip Code 21784			10g. Citizen of Wha	it Country?				
920	be filed within 72 hours atter death with the Maryland that Hygiene. Id other then "neturel", or Items 23e or 28e-f show event, I've Medical Exercites must be notified at	by Funerai	11. Marital Status 1: 1 Never Married 2 Married 3 X Widowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	J.	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 🛣 No	spanic Origin? n, Mexican, Pue Specify:	Specify Yes or No arto Rican, etc.)		American Indian, White, etc. 7hite				
Maryland 21215-0036	should be filed within 72 hound Mental Hygiene. I marked other then "netur umatic event, the Medical	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give life. L	tent's Usual Occupa kind of work done o DO NOT use retired acher	ution furing most of w)	orking	16b. Kind of Busin educati					
/land	uld be filed Mental Hyg irked othe	To Be C	17. Father's Name (First, Middle, Last) Joseph Thompson					ame <i>(First, Middle,</i> ilda Hans	Maiden Sumame) SON					
, Mary	and 2 should be salth and Mental n 27 is marked of er treumatic ev		19a. Informant's Name/Relationship (<i>Typ</i> Joseph V. Kelly (s			g Address <i>(Street a</i> Daniel C			nr, City or Town, Sta MD 20601	te, Zip Code)				
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta Importent: If item 27 is marked any njury or other treumatic e gnce.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	moval from State	County	sition (Name of natory or other place 7 Cremation	on 1-1			e, Md				
Balt	Depart Import any nj		21. Signature of Funeral Service Licenses Ought	Herbert	P.	.0. Box 19	95 Syke	sville, M	ld 21784	e & Chapel				
1	Physician		shock, or heart failure. List only one cause on each line.											
	/Medical Examiner	<u></u>		Alzherner 1	DIS	ease				3 years				
8760,	The law requires that the death certificate be executed ste has been signed by the attending physician and page 2 should be detached for use as the burial-transit	al Examiner	Sequentially list conditions, it any, leading to infinitely cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ					t Funeral Home & Chapel 1e, Md 21784 spiratory arrest, Approximate Interval Between Onset and Death J Week 3 4 2 3 4 2 3 4 2 3 4 2 4 3 4 3 4 4 4 4					
ဖ	artificate ing physi e as the t	Medical	d.											
.O. Box	at the death certific by the attending prached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3	Ectopic pregnancy Other (specify)				,				
Д.	w requires that been signed b should be deta		Part II. Other significant conditions cont	ributing to death but not resu	lting in the ur	nderlying cause give	n in Part I.			te to the cause of death? Probably 4 Unknown				
Il Records,		Completed						24a. Was autop perfor	sy prior med? deat	e autopsy findings available to completion of cause of h? Yes 2 \(\text{No} \)				
Vital	sicien: Th certificate irector, paç	Be	25. Was case referred to medical examiner?	ospital:	ER/Outpatien	Othe		eath (Check only o						
Division of	Attending Physicien: r death. sctor. Atter this certific. by the funeral director.	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	at ? es 2 No		ence 6 Other (Sow injury occurred	Бресіту)						
Divis	To the Höspite! or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,		eet, factory, office		28f. Location (S City or Tow		r Rural Route Number,				
1	B HÖSPI 24 hou B Funer etely fill	edical	29a. Certifier 1 - Certifying Physi (Check only one) 1 - Medical Examina	cian: To the best of my know er: On the basis of examinati and manner stated.	vledge, death on and/or inv	occurred at the time restigation, in my op	e, date and place inion, death occ	e, and due to the during at the time, d	ause(s) and manne date and place, and	r as stated. due to the cause(s)				
	To th within To th	Me	29b. Signature and title of certifier	70 = 50		29c. License		2	29d. Date signed (M	•				
7	in		30. Name and address of person when n						Januar	14,2004				
	IV		Ellis Mez M.D., 72					4						
	Sta Registr		JAN I	6 200 Registrar's Signat	and S	Segment.	, dili							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav **Physician** 01/14/2004 2:24 PM Richard Bernard Kennedy, Sr. /Medical 4e Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner North Arundel Hospital Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Months 160 M 2□ F Yrs. Director 67 MD 213-32-2359 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Anne Arundel Pasadena 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21122 U.S.A. 771 Woods Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 Married 1 ☐ Yes 2 MNo Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 9 Trucking Truck Driver 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) h end Mentel I 1 end 2 should be Emily Abbott Lippy William Edward Kennedy 19e. fnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Department of Health important: if Item 27 771 Woods Road, Pasadena, MD 21122 Patricia Kennedy/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/19/4 Glen Burnie, MD Glen Haven Mem Pk 21. Signature of Funeral Service Ligursee 22. Name and Address of Fecility G.J.Gonce Funeral Home, PA Tug 169 Riviera Dr., Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failur. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final diseese or condition resulting in death) /Medical Examiner lated Cardiomyopathy 5 years Examiner Physician: The law requires that the death certificete be executed Sequentially fist conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Division of Vital Records, P.O. Box 68760. Physician/Medidal Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? Completed completion of cause of death? 1 Yes 200 this certificate 1 ☐ Yes 2 ☐ NO spital or Attending Physician: Thours efter death.
Inersi Director: After this certificet by filled in by the funeral director, pe Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Medical Certification: To 1 | Yes 2 | ■ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28e. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturaf 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Plece of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital of within 24 hours e To the Funeral D completely filled is 1/2 crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner es stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier eller ! 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Of Burnie, MD 21061 Medison Park Whire Kevin Doyle MO

Registrar **DHMH 16 Rev 6/9**5

State

31. Date filed (Month, Day, Year)

2014 Registre's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		State of Maryland /	Certificate of Death	Reg. No. 2 0 (04 00885
		Decedent's Name (First, Middle, Last)	/	2. Dete of Deeth Month Dey Y	3. Time of Death
	Physician /Medical			January 2, 2004	5:30 AM
	Examiner	4e Fecility Neme (If not institution, give street end number)	4b. City, Town, or Lo		
		Hillside Assist LIVIN	9 Clarksvil bidhdayi If Under 1 Year If Under 24 Hrs.		
	Funeral Director	5. Social Security Number 6. Sex 1 M 2 F 86	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yeer) 0 3 28 1917	9. Birthplece (State or Foreign Country) MaryLand
	pue ≱	Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, To	own or Locetion		10d. Inside City Limits
	the Marylar 28a-f ehow notted at	111111111111111111111111111111111111111	Arksville		1 ☐ Yes 21 No
	ifter death with the Maint references or 28a-fe infer must be notified Funeral Director	10e. Street end Number 5502 Morris FARM LAN	21029	10g. Citizen of Wh	
21215-0020	by by	3 S Widowed 4 □ Divorced If Yes, Give Year or Detes:	 13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify: 	ecify Yes or No- Rican, etc.) 14. Race - Black, Specify:	American Indian, White, etc. Whit+e
5-0	72 hc	15. Decedent's Education 16 (Specify only highest grade completed)	6e. Decedent's Usuel Occupetion (Give kind of work done during most of working) life. DO NOT use retired)	ing 16b. Kind of Busin	ness/industry
121	led within 72 hoi yglene. Ner than "nature it, its Medical in Completed	Elementery/Secondary (0-12) College (1-4or 5+)			-
	Hygie With the Tart	10 0	secretary	med i e (First, Middle, Maiden Sumame)	
and	Sec ≥ m	7 1 7 1 1		Koperiva	
Maryland	should Men marke	-	9b. Mailing Address (Street and Number or Rure		rete, Zip Code)
Ma	nd 2 strict of the strict of t	Leonard Kavanaugh/son	18 Whips Lane Baltimo		
Baltimore,	Peges 1 a ent of Hea nt: If Item ry or othe	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	of Disposition (Name of tery, crematory or other place)	Date 20c. Location - Ci	ity or Town, State
Balti	permit. Pege Depertment of Important: If i any injury or once.	21. Signature of Euneral Service Licensee ROD Id S. Walle, Director	State Anatomy Board Baltimore, MD 2120	1	re Street
		23a. Pert Lenter the disease, or combinations that caused the death. Di shock or heart failure. List only one cause on each line.	o not enter the mode of dying, such as cardiac of	or respiratory arrest,	Approximate Intervel Between
1	Physician	Should heart lands. Est only one sause on book into			Onset and Death
16	/Medical Examiner	Immediate Ceuse (Final disease or condition	ween now SMAI	1 Type	URS
			a consequence of):	/ '	
	nsit	. Hyperte	NSION		GRS
Ć,	requires that the death certificate be executed been signed by the ettending physician and chould be deteched for use as the buniel-trensit etech by Physician/Medical Examiner	Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury	a consequence of):		1100
68760,	hysicia the bur	Ceuse (Disease or injury that initiated events Due to (or es a	a consequence of):		9.5
99	fifficate of the set the				i
Box	ettendir for use	d			
	the et hed fo	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23b. Did tobacco use contr	ibute to the cause of death?
P.0	that the led by the detech	anomia Hugothyra	oidism	1 ☐ Yes 2 ☐ No 3	Probably 4#-Unknown
ds,	signe d be d	A distribution of the state of	. 4.0	24a. Wes an eutopsy	24b. Were autopsy findings
of Vital Records,	> 100 -	Depression, Pyslipide	3MiA	performed?	available prior to completion of cause of death?
Be	The law sete hes be pege 2 s	Europhalopathie Coinel	Stenosis	1 ☐ Yes 2 TNo	1 ☐ Yes 2 7 No
ital	certificate rector, per	25. Wes cese referred to medical		h (Check only one)	
†	2 0 2	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/	Outpatient 3 DOA Other: 4 Nursing Ho	me 5 Residence 6 Other	(Specify)
0	ding Ph. h. After thi funeral	27. Menner of Death 28a. Date of Injury 28b.	D. Time of 28c. Injury at Work?	28d. Describe how injury occurred	j
Sio	at he	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be as a Blace of Injury. At home	M 1 Yes 2 No	9,000	
Division	or Att	determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Street and Number City or Town, State)	or Rural Route Number,
_	To the Hospital or Attending Pwithin 24 hours effer death. To the Funeral Director: Affer the completely filled in by the funeral Medical Certification:	29a. Certifier Certifying Physician: To the best of my knowled (Check only one) Company and manner stated.	ige, death occurred et the time, date end place, end/or investigation, in my opinion, death occurr	and due to the cause(s) and manned et the time, date and place, an	ner as stated. d due to the cause(s)
	within To the Comp	29b. Signeture end title of certifier Reilly MD	29c. License number D 5 4 7 4 4	l l	8 2004
		30. Name and eddress of person who completed cause of death (Item 23a)	1) (Type Print) 05 Benson Ave	Baltimore, M	021227
,4	State Registrar	31. Date filed (Month, Day, Year) / 32. Registrer's Signature	Annall &	,	
	negistrar	JAN 1 6 2004 ARMAN A.	Show of		

	1-	For State Registrar	State of Maryla	•	artment of <i>rtificate of</i>		•	giene Reg. No. 2	104	000
	1. D	ecedent's Name (First, Middle, La	st)				2. Date of De			3. Time of De
Physician		arthur	Funled	Kas	chub		Month	Day 2	Year O4	510
/Medical		Facility Name (If not institution, give	e street and number)	/(43		or Location of Death			ty of Death	J 1
Examiner	, , , , ,	1/ / /	1 11 0		1	Idock He	L		rede	wek
	5.5	Vindoboha /		. last birthday)			8 Date of Bird			
uneral rector	1		MM 2□F 93		Months Days		8. Date of Birt (Month, Da	y, Year)	Cou	olace (State or Fo
ECIO	1	al Residence of Decedent	1 75		l	_l,	Sept 6,	1910	Pen	nsy1vani
==	_	State 10b. County	10c. C	ity, Town or Lo	ocation				1	10d. Inside City L
a 5		MD Freder	ick I	and doe	le IIodah+	_				1 ☐ Yes 2
100	100	Street and Number	ICK I	raduoc	k Height	S		10. 0		
or other traumatic event, the Medical Examinar must be natified at To Be Completed by Funeral Director	100.	6012 Jefferson	D1J		10f. Zip Code	0171	- 1	10g. Citizen of		ntry?
1 E						21714			USA	
ring must be natified Funeral Director	11.	Marital Status	12. Was Decedent Ever in U Agned Forces?	J.S. 13.	Was Decedent of If Yes, specify Cut	Hispanic Origin? (Sp pan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Ra	ice - Americ ack, White,	can Indian, etc.
E		Never Married 2 Married	1. ☐Yes 2 ☐ No If Yes, Give		1 ☐ Yes 2 🔯 No			Speci		ite
Completed by		3 ☑ Widowed 4 ☐ Divorced	Year or Dates: 43	- 45				Space	7. WI	1116
ete		15. Decedent's En (Specify only highest gra	ducation ade completed)	16a. Dece	dent's Usual Occu	pation	rion	16b. Kind of E	Business/In	dustry
횰	E	ementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	during most of work ad)	9			
Ş		12	3		contra	actor			heat:	ina
Be	17. 1	ather's Name (First, Middle, Last,				18. Mother's Nam	e (First, Middle,	Maiden Suma	me)	
1 1 1	1	Ewald Edward Kas	schub			Clara	Marie S	enn		
-		. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Stree	t and Number or Rur			, State Zin	Code)
- 1		Gail Farbman/da	ughter			a Drive Fr				0000)
	20a	Method of Disposition			sition (Name of		Date	20c. Location	21702	um Ctota
eny injury or other tr <u>once</u> .	1	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other (Specif	Removal from State	cemetery, crer	natory or other pla		Julio	200. Cocation	- City of To	wii, State
Buch	21.	Sign ture of Funeral S-ryice Licer RONA d S	Had Dinecto	r St	Name and Address ate Anat 1timore,	ess of Facility COMY Board	655 W.	Baltim	ore S	treet
	232	Part Enter the disease/or com	nications that caused the dea							Approximate
	4	Part Enter the disease or com shock or heart failure. List only	one cause on each line.			rig, such as cardiac	or respiratory an	65 1,		Interval Between Onset and Deat
an	dise	ediate Cause (Final ase or condition	a Pulmona	ry fibi	2320					Ugars
cal	resu	Ilting in death)	Due to (or as a consec	quence of):						7
er	Con	uantially list appditions	h							
= =	if an	y, leading to immediate	Due to (or as a consec	quence of):						
Examiner	Cau	uentially list conditions, y, leading to immediate se. Enter Underlying se (Directed or injury initiated events	•							
X	resu	Iting in death) Last	Due to (or as a consec	quence of):						
-										
号			. б.						-	
₹ S	IFF	EMALE:	000 Hunn automo al como						-	
Physician/Medica	23b.	Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	ldeath 3□	Ectopic pregnanc Other (specify) _	у			ate of delive onth	ry Day Year
	Part	II. Other significant conditions c	patributing to death but not re-	ulting in the ur	doching sauss an	unn in Don't	22a Did ta	haaan	4 al b	e cause of death
leted by P	3	Dansenlie					u.			
e e	1-	Delivertia,	Suspected p	" ~ STO.F	e canc	« /	1 ∐ Y	es 2 🗆 No	3 Proba	ably 4 Donkn
Completed by							24a. Was a		Were autop	sy findings avail
Сощр							autops	med2	death?	npletion of cause
	25 \	Vas case referred to medical				OS Place of De "			1 ☐ Yes	∠∟ N0
Be	6	xaminer?	Hospital:		Ott	26. Place of Death				
<u>P</u>		langer of Death	1 Inpatient 2 2	ER/Outpatien 28b. Time of	3U DOA	4 Mursing Ho)
Certification;		☑Natural 5 ☐ Pending	(Month, Day Year)	Injury	28c. Injur Wor	rk?	28d. Describe ho	ow injury occur	red	
cation		Accident investigation □ Suicide 6 □ Could not be			M 1 🗆	Yes 2 ☐ No				
		B Suicide 6 Could not be □ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stre	et, factory, office		28f. Location (St City or Town	reet and Numb	er or Rural	Route Number,
Ö	1							,, 5,4,5,		
Medical	29a.	Certifier 1 Certifying Phr (Check only one)	ysician: To the best of my kno iner: On the basis of examina and manner stated.	tion and/or inv	estigation, in my c	opinion, death occurr	ed at the time. d.	ate and place	anner as sta and due to	ated. the cause(s)
Š	29h	Signature and title of certifier	and mainer states.	· .	29c Licens	e number		Od Data sima	d /ldo-sth F	Dave Venel
Medical Certific	200.	1 /			250. Liberts	e Humber	-	9d. Date signe	u (Month, L	Jay, rear)
		Kathleen is	15thin M		D3	52073		1/8	104	
	30. N	lame and address of person who	and manner stated. Skyn Koompleted cause of death (Item Koompleted Skyn Koompleted Cause of death (Item Koompleted Cause of d	n 23a) (Type, i	Print)			, , , - 1	·	
	1 k	athleen W.	stem ms (010 NI	nth aux	Bruns	with i	4d 2	1716	
State	31. [Date filed (Month, Day, Year)	32 Registrar's Signa	ture						
istrar		**** 4 A 200	A Real A	1 Ann	d)					
ev 1/2001		JAN 1 6 200	THE PARTY OF	-	55					

		•	1 - For Amend Item #2	State of Maryland / Depart 0b-c per in G828 2/2	ment of Health and M 0/04 tas ficate of Death	nental Hygie	ne 2 0 0 4	00887
	-· · ·		1. Decedent's Name (First, Middle, Last,	1 this and	00	2. Date of Death Month	Day Yeer	3. Time of Death
	Physici /Medio		(Jarence	Lamoi			9 2004	6 ANY
4	Examin		4a. Facility Name (If not institution, give	1 11 - 2 2	b. City, Town, or Location of Death		4c. County of Death	0
			ruture core a	gruington	Baltimore Funder 1 Year If Under 24 Hrs.	Days of Birth	NI	4
	Funeral		5. Social Security Number 6. Se		f Under 1 Year If Under 24 Hrs. Ionths Days Hours Min.	8. Date of Birth (Month, Day, Ye	ar) 9. Birthpla	-11/ 4 11 1/4
	Director		Usual Residence of Decedent	0		JAN. 1, 1	923 Sout	HCAROLINA
	yland		10a. State 10b. County	10c. City, Town or Locat	ion	<i>∧</i>	10	d. Inside City Limits
	Mar Mar	ţo	MARILLAND N	/A X	BALTIMORE	CITY		1⊠Yes 2□No
	or 28	Director	10e. Street and Number		10f. Zip Code	1 /0g.	Citizen of What Count	ry?
	23a		507 N. ST.	RICKER STREET	2122	3	USA.	
	ar de	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	s Decedent of Hispanic Origin? (Spes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e	
36	within 72 hours after death with the Maryland ene. then "netural", or Items 23a or 28a-f show the Medical Examinar mast be notified at	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 XYes 2 □ No If Yes, Give 1 □ Year or Dates:	Yes 2 No Specify:		Specify: 13	BOV
21215-0036	2 hou	be l	15. Decedent's Edu	cation 16a. Deceden	t's Usual Occupation	. 16b	. Kind of Business/Ind	ustry
215	hin 7.	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+) (Give kin life. DO	d of work done during most of work NOT use retired)	king		
21	od with	Į.	12 HIGRADE	UNDE		DER B	ETHLEHEM	
nd	be filed tal Hygie d other	Be (17. Father's Name (First, Middle, Last)	UNKNOWN)	18. Mother's Nam	e (First, Middle, Mei	den Sumame) (UNK	No. ON)
yla	2 should be filed with and Mental Hygiene. Is marked other ther aumatic event, ILE II	၉						
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hyglene. item 27 Is marked other then "natural", or items 23a or 28a-1 show item traumatic event, the Medical Examinar mast be notified at	1	19a. Informant's Name/Relationship (T)	1 100	Address (Street and Number or Ru	ral Houte Number, Ci	n	Code)
	1 and 2 Health tem 27		20a. Method of Disposition	2 (COMMON LAW-WIFE) 1921 20b. Place of Dispositi	N, FULTON A	Date 200	Location - City or Tov	MO X/X/
o	Pages nent of the ant: If its		1 Burial 2 ☐ Cremation 3 ☐ F	cemetery_cremat	ory or other place) metery		ansdowne, 1	
Baltimore,	permit. Pages 1 a Department of Hes Importent; If item any injury or othe		 4 □ Donation 5 □ Other (Specify) 21. Signature of Euneral Service Licens 	90 22. N	ame and Address of Facility	20	TO FUNG	PAL HOME
Ba	permit. Departr Importe any inju		1 inhich 1	Welliam J	955 PH HU TO	NAVE	BALTO. M	0.21217
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	cations that caused the death. Do not enter the cause on each line.	he mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
	Pnysician	82 V	Immediate Cause (Final disease or condition	Dehudratio	n			Onset and Death
	/Medical		resulling in death)	Due to (or as a sequence of):	PI			
	Examiner		Sequentially list conditions,	(arcinoma	of lung			
	ed sit	Examiner	Sequentially list conditions, if any leading to mind a cause. Enter Underlying Cause (Disease or injury	Due to or as a consequence of:				İ
	xecut and al-trar	xan	that initiated events resulting in death) Last	Due to (or as a consequence of):				
68760	The law requires that the death certificate be executed ate been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dlcal E		1				
.89	tificat ig phy as the	led						
Box	death certific attending p	N/us	230. was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ed	topic pregnancy		23d. Date of deliver	
	e dea he att	sicia	in the past 12 months? 1 Yes 2 No		ther (specify)		Month I	Day Year
P.0	that the de led by the a detached	Physician/Me	9 Unknown	ntributing to death but not resulting in the unde	orbing cause given in Part I	23e Did tobac	co use contribute to the	a cause of death?
	ires tha signed I d be det	t by	Falt II. Other significant conditions co	thibuting to death but not resulting in the unite	mying cause given in r urci.	1 ☐ Yes		B. of
of Vital Records,	w require been sign	Completed				24a. Was an	24h Word guton	sy findings available
Rec	The law sate has page 2.	m d				autopsy	prior to com death?	pletion of cause of
a		e Co	25. Was case referred to medical		26 Place of Dea	1 ☐ Yes 2 🔀	No 1 □ Yes	280 No
Ē		To B	avaminer?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	04		6 ☐Other (Specify))
	g Physical dispersal di		27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe how i		
<u>i</u>	Attendin death. ctor: Afr y the fur	atio	1 Natural 5 Pending 2 Accident investigation	(, 25) . 52)	M 1 Yes 2 No			
Division	l or Atte after de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street building, etc. (Specify)	, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural tate)	Route Number,
	urs af urs af eral D						()	
1	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical		sician: To the best of my knowledge, death or ner: On the basis of examination and/or investand manner stated.				
	ro the vithin ? To the	Me	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month, D	Pay, Year)
	[(Amatin 1	I Malem MD	D 1550	3 [anuary,	13,2004
A	M		30. Name and address of person who c	ompleted cause of death (Item 23a) (Type, Pri	8) Jahi - 1	-DII	mos	12.17
	N		HMATUU N	MACEM, 5011) - MILIAIS	150170	d Com C	WIT
	Sta		31. Date filed (Month, Day, Year)	6 200 Registrar's Signature	A CONTRACT			
	Regist	all	PAR 54 4		×			

			For State Registrer	State of	Marylan	-	artment of tificate o			Re	g. No. 20	04	00888	
	Physici		1. Decedent's Name (First, Middle, L Anita Mar		Leubec	ker			هـــ. ا	Date of Death Month ズル 【	Day	Year O 4	3. Time of Death O113 M	
	/Medio Examin		4a. Fecility Name (If not institution, gr 10837 Archer L	ve street and numb			4b. City, Town	n, or Location	of Death		4c. County	of Death		
	Funeral Director				Age (In yrs. I 71	ast birthday) Yrs.	If Under 1 Ye Months Day		Min. (/	Date of Birth Month, Day, V 10 1	Year) 932	9. Birthpla Count Md	ace (State or Foreign try)	
	yland now		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo						10	Od. Inside City Limits	
	the Mar 28e-f sl	Funeral Director	Md Washin 10e. Street and Number	gton —————		Willi	amsport			10	g. Citizen of W	/hat Count	1 Yes 2 No	
	s 23e o	rai Di	10837 Archer L			0 40	21795		1-1-0 (016.)	VN-	USA 14 Base	America	an Indian	
036	s 1 and 2 should be filed within 72 hours affer death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. If Health ar 71 is marked other then "natural", or items 23e or 28e-f show other treumatic event, tre Maralcal Extractive transitive notified at	É	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date	es? ⊡rNo		Was Decedent of fYes, specify C			Yes or No- n, etc.)	Black	- America k, White, e Whit	etc.	
21215-0036	no 72 ho n natur Malical	Completed		rade completed)	lor E t)	(Give life.	tent's Usual Ock kind of work do DO NOT use ret	ne during mos tired)	st of working		бь. Kind of Bu laryland			
1212	iled with tygiene. her the		12		or 5+)	engin	eering			st Middle M	laiden Sumami	a)		
Maryland	12 should be filed within h and Mental Hygiene. 7 is marked other then "ireumatic event, ire Marked	To Be	Lafon Owens											
	and 2 sho salth and n 27 Is m- ier treum				ter)	4	-						Code)	
0	Pages 1 and 3 nent of Health int: If Item 27 iry or other tr				C	emetery, crer	natory or other p	olace)	Date -17-04			•		
Balti	permit. Pages Department of the Importent: If its any injury or of once.		17. Father's Name (First, Middle, Last) Lafon Owens 18. Mother's Name (First, Middle, Maiden Sumame) Hortense Herring 19a. Informant's Name/Relationship (Type, Print) Patricia Lingoski (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zipe State,											
	cale be executed Wedical Waminer and the burial-transit	dical Examiner	shock, or heert failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Poue to (or b. Due to (or c.	r as a consequ	uence of): uence of):	noti	ie Co	en de	Vie.	senla		Interval Between Onset and Death	
P.O. Box 68	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2 ☐ Fetat nt at time of de	death 3	Ectopic pregna Other (specify,				23d. Date Mon	of deliver	Y Day Year	
ecords, P.	w requires that been signed b should be deta	ρ	Part II. Other significant conditions			-	nderlying cause	-	De Jeon	1 3 Ye	s 2□No		e cause of death? ubly 4 □Unknown	
		Completed								24a. Was an autopsy perform 1 ☐ Yes 2	ed? pi	Vere autop rior to com eath? □ Yes 2	sy findings available in pletion of cause of 2 No	
Vital	Physicien: this certific ral director.	To Be (25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No	Hospital:	patient 2	ER/Outpatien	t 3 DOA	Othor	e of Death <i>(Chi</i>		nce 6 ⊡Othe	r (Specify))	
	fer fer fer		27. Manner of Death 1 Natural 5 Pending 2 Accident investigati	28a. Date of (Month,		28b. Time of Injury	28c. lr	njury at Nork?	28d. I		w injury occurre			
-	of or Attendi safter death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not determine	286. Flace 0	f Injury - At ho g, etc. <i>(Specif</i> y	ome, farm, str y)	eet, factory, offi	ce		ocation (Str. City or Town,		or Or Rural	Route Number,	
7	To the Hospitel of within 24 hours all To the Funerel D completely filled in	edical C		Physicien: To the beaminer: On the bas	is of examinal									
,	6	Me	29b. Signature and title of certifier	U. Dit	611	M	1	_	062	J		5,2	2004	
	(x)		30. Name and address of person wh	o completed cause	of death (Item	1 23a) (Type,	Print) 19	tales	store	and la	terro	21	742	
	Sta Registr		31. Date filed (Month, Day, Year)	1 6 200 R	gistrar's Signa	ture	· Salare							

			1 - For State Registrar			Marylan				lealth a		lental H	ygien	7111		00889
	Physic	ian	Decedent's Name	e (First, Middle, I	.ast)							2. Date of D Month	eath Da	av y	'ear	3. Time of Death
	/Med	cal	Muriel		Lumley							Januar	cy 11	, 200	4	10:35 A ^M
	Exami	ner	4a. Facility Name (/			ber)				Location o			40	County of		
	Funeral		5. Social Security N	coss Hos		'. Age (In yrs.	last birthday)	If Under		Sprin		8. Date of B	irth	Mont		
	Director		144-20-87	790	1□M 2\ F	76	Yrs.	Months	Days	Hours	Min.	8. Date of B (Month, D		77	Count lew .	ace (State or Foreign ry) Jersey
	pu .		Usual Residence of	Decedent 10b. County		140.00						Aug J	174			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	shore ed a	ō	MD	Montgo	m. o 14		y, Town or Lo								10	d. Inside City Limits
	28a-	Director	10e. Street and Nur		шету	511	ver Sp	rings 10f. Zip					40- 0:			Yes 2 No
	3a or	٥	2445 Lay		o Dood	11.00							USA	tizen of Wh	at Count	ry?
	death ms 2	Funerai	11. Marital Status	COUSVIII	12. Was Deced	#606 lent Ever in U.	.S. 13.		910 lent of H	ispanic Orio	ain? (Spi	ecify Yes or N		14. Race -	America	n Indian
9	or Ite			ied 2 Married	Armed Ford 1 Tyes 2 If Yes, Give						, Puèrto	ecify Yes or N Rican, etc.)			White, e	
9	72 hours after death with the Maryland natural', or Items 23e or 28e-f show dical Examiner must be notified at	d by	3 Widowed	4 Divorced	Year or Dat	es:		1 ☐ Yes	2ALI No	Specify:				Specify:	Wh	ite
15-	"natu	Completed by	(Spec	15. Decedent's lifty only highest g	Education rade completed)		16a. Deced (Give	kind of war	ok done d	turina most	of work	n <i>g</i>	16b. K	and of Busin	ness/Indu	ıstry
12	filed within Hygiene. Ither than "	l E	Elementary/Seco	ndary (0-12)	College (1-4	College (1-4or 5+)			DO NOT use retired)							
d 2		Be C	17. Father's Name ((First, Middle, Las				Homemaker 18. Mother's Name			(First, Middle	(First, Middle, Maiden Sumame,				
<u>a</u>	Mental Mental Mrked o	To B	Albert Me	eyers		Sarah Duffy						White D. Kind of Business/Industry Own Home den Sumame) Ty or Town, State, Zip Code) 5754 Location - City or Town, State				
Maryland 21215-0036	and and and and and and		19a. Informant's Na	me/Relationship	(Type, Print)		19b. Mailin	g Address	(Street a				ber, City o	or Town, Sta	ite, Zip C	Code)
	and eaith n 27		Robert Lu							ad Ki	1au e	a, HI	967	54		
Baltimore,	Se to I		20a. Method of Disp 1 Draurial 2 [☐Removal from St		lace of Dispo emetery, cren	sition (Nam natory or ot	ne of ther place	9)	С	ate	20c. Lo	ocation - Cit	y or Tow	n, State
ţ	t. Pa rtmen rtant: njury		° 4 ☐Donation	5 Other (Spec	ify)		Calva:					-04	Ne	tune	, NJ	
Bal	permit. Page Department of Important: If eny injury or once.		21. Signature / Fui	O by \	ensee	1001		Buck1	ey F	s of Facility unera	1 Hc	ome				
			23a. Part1. Enter th	ne disease, or cor	inplications that cau	ised the death	Do not ente	509 2	nd A	ve As	bury	Park,	NJ	0771		Approximate
	Physician		Immediate Cause (tialiure. Listoni Final	y one cause on eac	te and						-			l C	nterval Between Onset and Death
100	/Medical		disease or condition resulting in death)	•		as a consequ		LC Re	spir	atory	rai	lure			7	Days
. y	Examiner		Sequentially list con	nditions	Chr	onic Ob	struct	tive]	Pulm	onary	Dis	ease			10	Years
	sit ad	iner	Sequentially list con if any, leading to im cause. Enter Under Cause (Diseese or i	mediate tying	Due to (or as a consequence of):								TOUTD,			
/	xecute and Il-tran	Examiner	that initiated events resulting in death) L	_	c. Due to (or	as a consequ	ience of\:									
8760,	icate be executed physician and s the burial-transit	alE				as a consequ	ionce or).									
687	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical			d										-	
Вох	w requires that the death certific been signed by the attending p should be detached for use as	In/M	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outco	me of pregnar								23d. Date of	delivery	
	e deat	sicia	in the past 12 months? 1									Month	,	ay Year		
P.O.	at the	Phy	9 Unknown												_	
JS,	signer	by	Part II. Other signific Pneumonia	cant conditions	contributing to deat	h but not resu	Iting in the un	derlying ca	use give	n in Part I.		T .	obacco use contribute to the cause of death?			
Ö	requ	Completed									1X1	1 Yes 2 No 3 Probably 4 Unki			ly 4 □Unknown	
Bec	has l	mpi	Congestive	e Heart	Failure							24a. Was autor	osy	prior	to comp	y findings available letion of cause of
	in: Th	e Co	25. Was case referre	and to marking									rmed? 2⊠No	deat	n? Yes 2[□ No
5	Attending Physician: r death. ector: After this certifice by the funeral director.	To Be	examiner?		Hospital:	ationt 2 🗆 E	R/Outpatient	200	Other	_		(Check only o		1000		
ō	g Phy er the eral c	T.	27. Manner of Death		28a. Date of I	njury	28b. Time of		c, Injury	at Nurs	_	e 5 Resident			Specify)	
Ö	andin ath. or: Aft	atio	1 XNatural 2 Accident	5 Pending investigation		Day Year)	Injury	М	Work1 1 □ Y	? es 2∐No	D					
<u>S</u>	ter de irecto	Certification;	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	288. Place of	Injury - At hor etc. (Specify)	ne, farm, stre	et, factory,	office		2	8f. Location (5 City or Tox	Street and	d Number of	Rural A	oute Number,
Ω	urs aft			**							9					
	To the Hospital or Aftending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	29a. Certifier (Check only one)	1፟፟ Certifying Pl 2	nysician: To the be	s oi examinati	riedge, death on and/or inve	occurred at	t the time	o, date and pric	place, a	nd due to the	cause(s)	and manne	as state	nd. e cause(s)
	o the	Mec	29b. Signature and to		and manner	stated.			License							
	- 5 F 8) All	11 h. 1	Poll .									signed (M		
	X	-	30. Name and addre		completed cause of	of death (Item	23a) (Type P		D223	09			Janu	ary 1	L, 20	004
_	0			W. Poth		13 F1or			Si1	ver S	prin	g. MD	2001	R		
	Sta		31. Date filed (Month		32. Regi	strar's Signatu	ile 💆				لفشيسي	O 3 1111	- U J I (·		
	Registra		MILL	FILLS OF I	hi had still a	2 87	CANGAR	A. Commercial Commerci								

		·	1- State of Maryland		artment of Health and I <i>rtificate of Death</i>	Mental Hygieı .Reg	_ 2001	0039			
	Physici		Decedent's Name (First, Middle, Last) Helen Dolores Lynch			2. Date of Death Month January	14, 2004	3. Time of Death 12:45 p.M			
	/Medie Examir		4a. Fecility Name (If not institution, give street and number) Crofton Convalescent Center		4b. City, Town, or Location of Death	· · · · · ·	4c. County of Deeth Anne Arundel Co				
	Funeral Director		5. Social Security Number 214-08-9781 6. Sex 1 M 2 2 F 7. Age (In yrs. In 77)	st birthday) Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Aug. 12,	9. Birth 1926 Ma	26 Maryland			
036	e Maryland Sa-f show	Director	10a. State 10b. County 10c. City,	Town or Lo				10d. Inside City Limits 1 ☐ Yes ※XX No			
	ath with th	ral Dire	10e. Street and Number 2131 Davidsonville Road		10f. Zip Code 21114		United St	tates			
	72 hours after death with the Maryland natural', or Items 23a or 28a-f show alseal Exertines must be putitled at	by Funeral	11. Marital Status 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 ☐ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White, Specify: Wh				
21215-0036	within ene. then	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Ootlege (1-4or 5+)	(Give	dent's Usuat Occupation kind of work done during most of wor DO NOT use retired) Disabled	king 16b	. Kind of Business/Ir n/a	ndustry			
Maryland 2	be filed stal Hyg ed other	To Be C	17. Father's Name (First, Middle, Last) Charles E. Lynch			Tyler	len Sumame)				
	nd 2 shoulth and 27 is m		19a. Informant's Name/Relationship (Type, Print) Mrs. Elizabeth L. London/Sister	61 E	<u> </u>	hoboth Bea	ch, Delaw	are 19971			
Baltimore,	Pa ant ury		1	metery, crer lens o	f Faith Cem. Jan.	16,2004	Baltimor	e, MD			
Bal	permit. Pa Departmen Important: eny injury 2005.		21. Signature of Funeral Service Licensee Michael E. Canar		2. Name and Address of Facility Leonard J. Ruck,	Inc. Bal	5 Harford timore, M	D 21214			
力	Physician /Medical Examiner										
98760,	icate be executed physician and sthe burial-transit	edical Examiner									
Box	death certil e attending id for use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnan 1 Live birth 2 Fetal december 4 Pregnant at time of december 5 Value 1	□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day						
rds, P.O.	law requires that the deas been signed by the a	by	Part ii. Other significant conditions continuously to death but not resolving in the underlying cause given in Part i.								
Il Records,	The are ha	Completed		24a. Was an autopsy performed 1 Yes 2 1	sy prior to completion of cause of						
ivision	Attending Physician: Th r death. sctor: After this certificate by the funeral director, pag	To Be		R/Outpatier 28b. Time o Injury	of 28c. Injury at 28d. Describe how injury occurred						
	in Direction	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At hombuilding, etc. (Specify)	ne, farm, str	reet, factory, office	28f. Location (Street City or Town, St	and Number or Rura ate)	al Route Number,			
	the Hospital hin 24 hours a the Funeral t upletely filled	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my know 2 Medicel Examiner: On the basis of examination and manner stated.								
5	To the l within 2 To the l complet	M	29b. Signature and title of certifier		29c. License number 3 5 9 5 8	29d. [Date signed (Month,	Day, Year)			
	Sta		30. Name and address of Berson who completed cause of death (Item 31. Date Hed (Month, Day, Year) 32. Registrar's Signature	113 M	napola had i	#106 OU	lenten N	1021113			
	Regist	ar	JAN 1 6 2004 Amaria. Ac	Buch	all p						

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** ewis 2320 M ohn banucure 9 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Bayview Medical Center Johns Hookins
5. Social Security Number timore 8. Date of Birth (Month, Dey, Year) April 12,1952 If Under 1 Year 7. Age (In yrs. last birthdav) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days 1**X** M 2□ F Hours Min. 219-60-8672 Yrs. Maryland Director 51 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2 No Directo Edgmere Marvland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21219 United States 2121 Sparrows Point Road Funeral r death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. pernit. Pages 1 and 2 should be filed within 72 hours atler Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or the any injury or other fraumatic event, Ita Medical Examina 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2XXXNo Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Appliance Repair Appliance Repairman 8 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary Carmela Perry James Howard Lewis, Sr. 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenwood, Maryland 21238 14078 Gared Drive Michael Lewis (Son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ₩ Burial 2 Cremation 3 Removal from State Gardens of Faith Cem. 1/16/2004 Rosedale, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Ligense with 7922 Wise Ave. Dundalk, Maryland art 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failure Immediate Cause (Final **Physician** De PSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Monocytogenes Examiner Listeria bacteremia da Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed _irrhosis ears use as the burial-tran attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown ed by 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. by of Vital Records. been signe should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate 1 Tes 2 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Yeer) within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27 Menner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier. RES -000 10,2004 600 North Wolfe Street 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Schiffer, MO Johns Hopiens Hospital Town 119 Doctors Louise Tisdell Joshun Paltimores Mc 21287 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JAN 1 6 2004 Registrar

		1- For State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.										
	Physici	an	1. Decedent's Name (First, Middle, La	ist)	LAMISON	2. Date of Death Month	Dey Yeer 13 2004	3. Time of Death				
	/Medic Examir		4a. Facility Name (If not institution, give	re street and number) EDICAL CENTER	4b. City, Town, or Location of Death BALTIMORE		4c. County of Death					
	Funeral Director		231-16-8632	Sex 7. Age (In yrs. last birthda 1⊊ M 2□F 79 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Aug. 15,	ear) Cou	place (State or Foreign intry) ryland				
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits				
	ours aftar death with the Meryland rai', or itema 23a or 28a-f ahow Examiner must be notified at	Funeral Director	Maryland Balt	timore	Dundalk	100	Citizen of What Cou	1 ☐ Yes 2♥ No				
	3a or	흐	222 Maple Ave.		21222		nited Sta					
		nera	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		14. Race · Ameri Black, White	can Indian,				
920	hours aftar tural', or ite		1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII	1 ☐ Yes 2 ☑ No Specify:	or mount, order,	Specify:	White				
5-0	72 ho	eted	15. Decedent's E (Specify only highest gr	ducation 16a. Dec	cedent's Usual Occupation ve kind of work done during most of won	king 16b	b. Kind of Business/Ir	ndustry				
21215-0036	s 1 and 2 should be filed within 72 hours a if Health end Mental Hyglene. Item 27 is marked other than "natural", o other traumatic avent, the Medicel Exer	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+) 1 Year M:	ilitary	ט	nited Sta Governmen					
Maryland	tal Hy ad oth	B	17. Father's Name (First, Middle, Last			ne (First, Middle, Maid	den Sumame)					
17	should nd Mer marku matic	ျ	George D. Lamis 19a. Informant's Name/Relationship		illing Address (Street and Number or Ru	a Rogers	ty or Town, State, Zi	Code)				
Na Na	and 2 should be faith end Mental P 27 is marked of ar traumatic ava				34 Montview Ct. Co							
Baltimore,	of He		20a. Method of Disposition № Burial 2 ☐ Cremation 3 ☐	Removal from State 20b. Place of Dis	position (Name of rematory or other place)	Date 20c	. Location - City or T	own, State				
E	it. Pag riment riant: njury o		4 □Donation 5 □ Other (Special	Oak Lawr	Cemetery 1/16/200)4	Baltimore	, Maryland				
Bal	permit. Pages Depertment of the important: If Italiany or of any injury or of once.		21. Signalore of Funeral Service Licensee) 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222									
	Physician /Medical		shock, or heart failure. List only		ABDOMINAL AN			Approximate Interval Between Onset and Death				
			Immediate Cause (Final disease or condition resulting in death)		1 nour							
1	Examiner			Due to (or as a consequence of):								
у	= g	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):								
	end end I-trans	xam	Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or as a consequence of):							
8760,	cate be executed physicien end the burial-transit	dical Examiner		d								
9	ndificating physes the		IF FEMALE:					,				
P.O. Box	requires that the death cerifiinen is signed by the attending the hould be deteched for use as	Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		B □Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year					
	quires that n signed b uid be dete	d by Pł	Part II. Other significant conditions	contributing to death but not resulting in the		co use contribute to t	he cause of death? pably 4 @Unknown					
Records,	> D iii	omplete				24a. Was an autopsy performed	? prior to co	opsy findings available impletion of cause of 22 No				
of Vital	ician: sertific actor,	Be	25. Was case referred to medical examiner?	Hospital:	Other	h (Check only one)						
of	Physic ruthis or raidir	2	1 ☑ Yes 2 ☐ No 27. Manner of Death	1 Inpatient 2 ER/Outpati		ome 5 Residence		(y)				
o	nding th: ; After e fune	atlon	1 Natural 5 Pending 2 Accident investigatio	(Month, Day Year) Injury			,,					
Division	ii or Attai after des i Diractoi d in by th	Certification;	3 Suicide 6 Could not be determined		28e. Place of Injury - At home, farm, street, factory, office 28f. I			Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical C		nysician: To the best of my knowledge, de miner: On the basis of examination and/or and manner stated.								
	To the Within To the	Me	29b. Signature and title of certifier Held (e MD	29c. License number $RES-OC$	29d. (Date signed (Month,					
) (1/			completed cause of death (Item 23a) (Typ		1						
	Sta			32. Régistrar's Signature		,		*				
	Registr	ar	ONN TO	production of								

State of Maryland / Department of Health and Mental Hygiene 🗦 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 4.37 PM anuary 2004 99 ruder 119M 191 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) Examiner Samonitan Baltimore 110s pi MA If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2□F Missi 426-05-6538 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location or 28a-f show 7 is marked other than "natural", or itema 23a or 28a-f abov traumatic event, it a Medical Exert and marke colling at 1 Yes 2 □ No Director MD BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21212 MELRUSE 122 AVE Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ✓ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 2VNo Specify: Yes, Give Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) sychiati 12 ould be filed v Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Wailes Magruder 0 ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Çity or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If Item 27 is
any injury or other trau lliam 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) -04 Forest Hill MD 4 Donation 22. Name and Address of Facility 2325 YOKK D. TIMONIUM MV 2169 21. Signature of Funeral Service Licensee W/Olto PEACEFUL ALTERIDATIVES FUNERALOCREMATION Part 1. Enter the disease recomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List pnly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 140cardial -u tai /Medical Due to (or as a consequence of) **Examiner** Arter Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner use as the burial-transit The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 moriths?
1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Aureus Pheumonia table 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? certificate 2 No 1 Yes 2 No 1 Yes or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Hospital: 1 Vinpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA Certification: To this 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral. 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d, Date signed (Month, Day, Year, 29b. Signature and title of certifier Nicolai Mejevoi January 13th, 2004 RE2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 Lock Rowen Blud, Baltimore, MD 21239 Nicolai **ME7EAOI** 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

A SOLL S

ORIGINAL

	For State Registrar	State of Maryland		of Health and le of Death	Mental Hygie	LUU4	00894		
Physician	1. Decedent's Name (First, Middle, Last)		Mclaud	blio	2. Date of Death Month	Day Year	3. Time of Death		
/Medical Examiner	4a. Fecility Name (If not institution, give s Johns Hopkins Bau		4b. City,	Town, or Location of Deat 21th more Ci		4c. County of Death Baltimo	re City		
Funeral Director	5. Social Security Number 6. Sex 212-36-8777				8. Date of Birth (Month, Day, Ye	9. Birthp Cour	place (State or Foreign otry)		
faryland show	Usual Residence of Decedent 10a. State 10b. County		, Town or Location			1	0d. Inside City Limits 1 ☐ Yes 2 ☑No		
with the Mar sa or 28a-1 s 1 be notified I Director	Maryland Baltim 10e. Street and Number 1817 Merritt Blve		10f. Zip		dalk 10g.	Citizen of What Cour			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show amorian; if item 27 is marked other than "natural", or items 23a or 28a-1 show are in items of the confiled at an are in items. To Be Completed by Funeral Director		2. Was Decedent Ever in U. Armed Forces? 1	S. 13. Was Deced	ent of Hispanic Origin? (S ify Cuban, Mexican, Puen	pecify Yes or No- o Rican, etc.)	United S 14. Race - Americ Black, White, Specify:	an Indian,		
be filed within 72 hours after death with the Maryland that Hygiene. Indicate than "natural", or items 23a or 28a-f show evant, the Medical Exercipar must be notified at Be Completed by Funeral Director	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	16a. Decedent's Usua (Give kind of wor life. DO NOT us	l Occupation k done during most of wor e retired)	rking 16b	b. Kind of Business/In	dustry		
ontal Hygien ed other th evant, the	12 Years 17 Father's Name (First, Middle, Last) Howard J. Horne		Super		me (First, Middle, Maid				
a z should lith and Meni 27 is marke r traumatic To	19a. Informant's Name/Relationship (Type Darlene Bittinger	•		(Street and Number or Rumeyer Road I		ity or Town, State, Zip	Code)		
nent of Hea ant: If itam ury or othe	20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ R □ □ Donation 5 □ Other (Specify)	BINOVALITORI STATE	lace of Disposition (Namenetery, crematory or o	ne of ther place)	Date 200	Location - City or To	wn, State Maryland		
Departm Departm Importa any inju once.	21. Si nature of Funeral Service License		22. Name an	Address of Facility Ruck Funeral Vise Ave. D					
res that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit by Physiclan/Medical Examiner	a Mitral are knosis								
gned by the attending pt be detached for use as th by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown		23d. Date of delive Month	ery Day Year				
should be deta	Part II. Other significant conditions con	23e. Did tobac	Did tobacco use contribute to the cause of death?						
cate has been s page 2 should	24a. Was an autopsy prior to autopsy prior to autopsy prior to the second secon								
After this certifications of the control of the certification of the cer	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	ospital: 1 Anpatient 2 28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	A Other: 4 Nursing H	ath (Check only one) Home 5 Residence 28d. Describe how i	njury occurred			
rtal or irs afte ral Dir led in Cert									
thin 24 hours the Fune the Fune mpletely fill	29a. Certifier (Check only one) 1 Solution Check only one) 2 Medical Examination Check only one)	ner: On the basis of examinal and manner stated.	tion and/or investigation	in my opinion, death occu	urred at the time, date	and place, and due to Date signed (Month,	the cause(s)		
	1 Dent	Medical Do	te-	Res-000	7	January 13	12004		
State Registrar	Sohn Mayen, The 3 31. Date filed (Month, Day, Year) JAN 1 6 201	32. Registrar's Signa	ture		et, Baltimon	e May land	21237		

		1 - For State Registrar	State of Maryla	nd / Depa <i>Cei</i>	artment of H	lealth and l Death		giene leg. No.	2004	00095		
- S	1. Decedent's Name (First, Middle, Last)						2. Date of Dea Month	ith Day	Year	3. Time of Death		
Physici /Medi		VIRGINIA		1	1ELVIN	7	JANUAR			0805 AM		
Examir		4e. Fecility Name (If not institution, give	e street and number)		4b. City, Town, or	Location of Deat	h , /	4c. C	County of Deeth			
		The Johns Ho	Pkins Hospin	tal	Daltir	nore C	ity					
Funeral		5. Social Security Number 6. S		. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day	, Year)	Cou	plece (State or Foreign ntry)		
Director			¹ □M ²	Yrs.			Aug 21,	191		ginia		
pu »		Usuel Residence of Decedent 10a. State 10b. County	100.0	ity. Town or Lo	nastion .					10d. Inside City Limits		
aryla •hot	_	MD		,,						1 Tyes 2 No		
Ba-f	Director			Baltimo					(1111 . 0	Λ		
with t		10e. Street and Number	_ 1		10f. Zip Code				en of What Cou	ntry?		
death with the Maryland ms 23a or 28a-f ehow from the political and	Funeral	4202 Wickford Ro	· · · · · · · · · · · · · · · · · · ·	110	21210			USA	4. Race - Amer	and to disc		
er de Item	nue	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ever in I	0.5.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S in, Mexican, Puer	to Rican, etc.)	12	Black, White			
S aft	by F	3 Widowed 4 Divorced	1 XYes 2 □ No If Yes, Give 1942 Year or Dates:	2 –	1 ☐ Yes 2 ☐ No	Specify:		Specify: White				
5-UU30 72 hours after natural; or ite	pa		15. Decedent's Education 16a. Decedent's Usual Occupation									
0 In 72	Completed	(Specify only highest gr	(Specify only highest grade completed) (Give kind of work done during most of work							idddify		
within liene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		Nurse			Н	City or Town, State, Zip Code) MD 21210 Oc. Location - City or Town, State Stanley, VA			
nd Z1Z1 e filed within al Hygiene. Lother than "	Ö	17. Father's Name (First, Middle, Last)			18. Mother's Nar	ne (First, Middle,					
d be ental	To Be	Homer Allan Lest	er			Edith	Brown K	oont	z			
naryian naryian 2 should be and Menta and Menta i and marked	-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailie	ng Address (Street	and Number or Ru	ıral Route Numbe	r, City or	Town, State, Zi	o Code)		
Ma nd 2 sl lith and 27 le r r traur	-	Susan Allen Melv	in - Daughter	4202	Wickford	Road Ba	ltimore,	MD	21210			
BAIRTIMOTE, MATYIANG Z1Z15-0U30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-1 show any injury or othar traumatic event. If a Medical Exercitive Caral Exercitive and Lancollist and once.		20a. Mathod of Disposition	20b.	Place of Dispo	sition (Name of matory or other place	10)	Date	20c. Loc	ation - City or T	own, State		
altimor		1 Burial 2 Cremation 3 C 1 Donation 5 Other (Speci	Removal from State	•	hapel Cem		9-04	Ctan	1 011 17 1			
nit. F artme ortar injur	li	21. Signal re of Funeral Service Lice			2. Name and Addres	ss of Facility			rey, VA			
Dermi Depa Impo		M1001 117	O splow		Bra	dley Fun	eral Hom					
		23a. Part . Enter the disease or com	plications that caused the dea	ath. Do not ent			St. Lur		VA	Approximate		
	- 1	shock, or heart failure. List only	,	4								
Physician /Medical		disease or condition resulting in death)	a. Due to (or as a conse	ung (ance	V				william		
Examiner			Due to (or as a conse	iquenca_pr):								
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):										
pet Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infiltated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):										
al-tra	Xa											
OX 68 fou, certificate be executed rding physician and use as the burial-transit	icai l											
ficate as the			0.									
BOX 68 Jeath certifica attending ph	ian/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr					23	d. Date of deliv	erv		
death death death deaten	ciai	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)					Monti				
	Physicia	9 Unknown	9□ Unknown									
that the ned by the detache	y P	Part II. Other significant conditions	contributing to death but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco us	e contribute to I	he cause of death?		
Ords, requires een sign rould be	d by						1 □ Y	es 2 🗆	No 3 Pro	bably 4 Unknown		
() > ¹ / ₁	Completed						24a. Was a	10	24h Were auto	opsy findings available		
VITAL MEC. ilcian: The law certificate has b	Ē						autops	sv	prior to co	mpletion of cause of		
r: Th		BE III						2 □ No	1 🗆 Yes	2)(1) No		
	Be	25. Was case referred to medical examiner?	Hospital:		oth		ath (Check only or					
OF Phys	٠ <u>۲</u>	1 ☐ Yes 2 No 27. Manner of Death	1 Apatient 2L	28b. Time of	IL SU DOA	4 Nursing F	fome 5 ☐ Reside			fy)		
ding After	Fig	Natural 5 Pending	28a. Date of Injury (Month, Day Year)	Injury	Worl	k? Yes 2 ∐No		28d. Describe how injury occurred				
JIVISION I or Attending after death. Director: After I in by the fune	Certification;	3 Suicide 6 Could not b	98 Place of Injury At	home, farm, str			28f. Location (S	28f. Location (Street and Number or Rural Route Number,				
Jor A affer Dire	erti	4 Homicide determined	building, etc. (Spec	cify)	oci, idotoly, olilo		City or Town	n, State)		a riodio riambor,		
spita ours neral		29a. Certifier TS Certifying P	nysicien: To the best of my kr	nowledge, deat	h occurred at the time	ne, date and place	and due to the c	ause(s) a	nd manner as	hatet		
DIVISION OI To the Hospital or Attending Ph. within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edical	(Check only 2 Medical Exa	miner: On the basis of examinand manner stated.	nation and/or in	vestigation, in my o	pinion, death occu	irred at the time, d	late and p	lace, and due t	o the cause(s)		
To the within 2 To the	Me	29b. Signature and title of certifier			29c. License	e number (T	1372) 2	9d. Date	signed (Month,	Day, Year)		
P \$ P 0		A fora	M Clania	MT	7000	Tarlin	1010)	1	1010			
		30. Name and address of person who	completed cause of death (lite	em 23a) (Tyne		59240			1710	7		
		LENIA (HENI	M.D. Toffor		illding,	601 N. 1.1	offest	Rol+	man	MD		
St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign		90	PO 1 14.00	011-1	<u> </u>	i nave	(**(1)		
Regist		IAN 1 6 2	1994 Sener	2	ADDR A	11						

State of Maryland / Department of Health and Mental Hygiene State AMEND ITEM #19a PER ANA BD G827 1/20404file to of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** Robert S. Mosser January 11, 2004 12:22 AM /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1X M 2□F 81 217-18-4731 1, 1922 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ed other than "natural", or iteme 23s or 28s-f show event, the Medical Examiner mass be indiffied at 1 ☐ Yes 2√ No MD Baltimore Towson Director the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 902 Starbit Road 21286 <u>USA</u> by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S.
Armed Forces?

1 ∑Yes 2 □ No 43-46 Peges 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 51-54 1 ☐ Yes 2 🔀 No Specify. Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Mental Hygiene. physician medical 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) permit. Peges 1 and 2 should be it Department of Health and Mental F Important: If item 27 le marked ot any injury or other treumatic ever David Black Mosser Sophia Agatha Schaaf 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) FILEN FILEAbeth Mosser/spouse 902 Starbit Road Towson, MD 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Rona Id State Anatomy Board 655 W. Baltimore Street tor man Baltimore, MD 21201 23a. Part 1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition CANCER menth **Physician** UNG resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 3 Probably 4 □Unknown Yes 2□No Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 M No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has funeral director, page 2 this certificate or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA 1 Yes 2 No Medical Certification; To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death After Injury Division 1 Natural 2 Accident 5 Pendina within 24 hours after death.

To the Funerel Director; Af
completely filled in by the fu 1 ☐ Yes 2 ☐ No М death. investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) he 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier JANUARY 11,2004 1775,705 30. Name and address of person who completed cauce of death (Item 23a) (Type, Print) 6701 N. Charles St. BALto Md 21804 6 BMC 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 1 6 2004 Registrar

			For State Registrar	State of Ma			of Health of Death			ene _{g. No.} 2 () () L _j	00897	
	Physici	an	1. Decedent's Name (First, Middle, Last		4 4 5				2. Date of Death Month JANVARY	Day	Year	3. Time of Death	
4	/Medic	al	4a. Facility Name (If not institution, give	VARTHA N	LAVONE	4h City To	wn, or Location	of Death	PANNALY	10	2004	U328+M	
	Examin	er	Washington County			77	erstown				shingt	On	
	Funeral Director		137-32-8208	x 7. Age	(In yrs. last birthday 90 Yrs.	If Under 1		r 24 Hrs	8. Date of Birth (Month, Day, Mar 3, 1		9. Birthp Coun	lace (State or Foreign try) York	
	/land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation					10	Od. Inside City Limits	
	e Man	ctor	MD Washingt	on	Hage	erstown					1 ☐ Yes 2√ No		
	with th	Director	10e. Street and Number			10f. Zip Co			10	g. Citizen o	. Citizen of What Country?		
	death ms 23	Funeral	333 Mill Street	12. Was Decedent Ev	ver in U.S. 13.	Was Deceden		740 rigin? (Spe	cify Yes or No- Rican, etc.)	USA 14. Race - American Indian,			
21215-0036	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28s-f show event, I'm Medical Evanimer must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🎇 Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:			Cuban, Mexica		Hican, etc.)	Spec	lack, White, o	etc. ite	
<u>.</u>	72 h	letec	15. Decedent's Edu (Specify only highest grad		16a. Dece (Giv	edent's Usual C	Occupation done during mo- retired)	st of worki	ng 1	6b. Kind of	Business/Inc	lustry	
212	within iene. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) //re.	teac				educa	ation		
פ	be filed ital Hyg id other	Be C	17. Father's Name (First, Middle, Last)				18. Moth	er's Name	(First, Middle, M				
<u>X</u>	should be nd Mental marked o umatic eve	To	Martin Francis Mu						Martha				
Maryland	Z de r		19a. Informant's Name/Relationship (T) Patricia Toffling				treet and Numb 0 Sharp		I Route Number,	City or Tow L 782	n, State, Zip	Code)	
Baltimore,	6 9 E 2		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ f 4 ☒ Donation 5 □ Other (Specify)	Removal from State	20b. Place of Disp		of				n - City or To	wn, State	
Baltır	permit. Pages 1 Department of H Important: If ite any injury or ott		21. Signature of Funeral Service Licens						655 W.	Balti	nore S	treet	
	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a. COVO	he death. Do not en	ATCIMOT oter the mode o	7	s cardiac o	r respiratory arres	it,		Approximate Interval Between Onset and Death	
	/Medical Examiner	10	1	Cang.	consequence of):	He	art	Fai	lure				
-	te be executed ysician and te burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Diab	consequence of):	Me	litu	5					
.O. Box 68	the death certificat y the attending phy iched for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Dive birth 2 4 Pregnant at ti 9 Unknown	Fetal death 3	□Ectopic pregr □ Other <i>(specn</i>					ate of deliver	ry Day Year	
ds, P	luires that the de n signed by the a uld be detached f	by	Part II. Dther significant conditions co	ntributing to death but	not resulting in the	underlying caus	se given in Part	I.		cco use co	ntribute to the	e cause of death?	
	sician: The law requires that the certificate has been signed by th rector, page 2 should be detache	Completed							24a. Was an autopsy performe	d?	Were autop prior to corr death? 1 \(\text{Yes} \)	osy findings available inpletion of cause of	
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	2 ER/Outpatie	-1 2 DO1	Othor		(Check only one)				
	Je isign	-	27. Mapmer of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day)	28b. Time o		Injury at Work?	2	ne 5 Residen 8d. Describe how)	
DIVISION	al or Attending P after death. I Director: After t d in by the funere	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	y - At home, farm, si (Specify)	treet, factory, of	ffice	2	8f. Location (Stre City or Town,	et and Nun State)	ber or Rural	Route Number,	
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical C	29a. Certifier 1 ✓ Certifying Phy (Check only one)	sician: To the best of ner: On the basis of e and manner state	xamination and/or in	th occurred at to	he time, date ar my opinion, dea	nd place, a ath occurre	nd due to the cau d at the time, dat	se(s) and n e and place	nanner as sta , and due to	ited. the cause(s)	
	To the within To the comp	W	29b. Signatur, and title of certifier	ruhed		29c. Li	cense number	39	6 290	I. Date sign	ed (Month, E	Pay, Year)	
			30. Name and address of person who co		th (Item 23a) (Type	Print)	lager	sto	6 wn M	ary	land		
	Sta Registr		31. Date filed (Month, Day, Year) JAN 1 6 2004	2. Registrar	s Signature	de							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item #18 per fn G827 1/22/04 tas

State of Maryland / Department of Health and Mental Hygiene 2 0 0 1

Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Max D. Nordeck Jan. 10, 2004 4:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 1209 Tucker Lane Ashton Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 3, 1920 5. Social Security Number Birthplace (State or Foreign Country) Months Days Hours 219-01-6698 1 XM 2 ☐ F 83 Yrs. Maryland Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Montgomery Director Ashton 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1209 Tucker Lane 20861 U. S. A. Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ∰Yes 2 □ No 1942−
If Yes, Give
Year or Dates: 1950 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No Specify: White ۾ 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Dentist Dentistry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Roy Nordeck Lucy Hall Lucy Hall 19a Informant's Name/Relationship (Type, Print)
Claire S. Nordeck, wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1209 Tucker Lane Ashton, MD. 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Lakeview Memorial Park 12-14-04 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Sykesville, MD * 4 ☐ Donation 5 ☐ Other (Specify) 1/14/04 22. Name and Address of Facility
Ambrose Funeral Home, Inc. 21. Signature of Euneral Service Licensee 1328 Sulphur Spring Rd. Arbutus, MD. Approximate Interval Between Onset and Deal 23a Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ARRHYTHMIA -ARDIAC Due to (or as a consequence of): ARTERY DICEASE MONAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Dav 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ SEMA 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autonsy perform 1 Tyes 2. No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Yes 2 ₩6 ို 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Medical Certification; 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Alatural 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1: Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

attending physician and for use as the burial-transit been signed by the should be detached Records. Division of Vital After this certific funeral director, within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Hospite

Funeral

ir than "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at

Maryland 21215-0036

Baltimore.

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If Item 27 is marked other than

or other train

Pnysician

/Medical

Examiner

State

Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

30. Name and address of person who

1-

TERR

pleted a e of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

JANNARY 12 2004 ELICOTT CITY

		For Amend Item 1 State Registrar 1. Decedent's Name (First, Middle, Las	per information	Cei	rtificate of	Death	Reg. 2. Date of Death		3. Time of Death
Physici /Medic		DORI			NEY		January	Day 1 + 200	49:20AM
Examin	er	4a. Facility Name (If not institution, give	0 0 11	nove	4b. City, Town, o	r Location of Death		4a County of Dea	N/A
Funeral Director		213 10 3007	ex 7. Age (In	yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye APR.5,19	9. Bir	thplace (State or Foreigountry) MD
MO M	}	Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town or Lo	ocation				10d. Inside City Limit
lems 23a or 28a-f show at must be multiled at	ctor	MD N	N/A	BAL	TIMORE				1 Yes 2 N
or 28	Funeral Director	10e. Street and Number	_		10f. Zip Code	04045	10g.	. Citizen of What C	•
IS 236	erai	3800 GLEN AVENUE	12. Was Decedent Ever	in U.S. 13.	Was Decedent of H	21215 dispanic Origin? (Sp	pecify Yes or No-	14. Race - Am	U.S.A.
or Ite	by	1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 🌠 No	an, Mexican, Puerto Specify:	Rican, etc.)	Black, Whi	
	eted	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16a. Dece	dent's Usual Occup	pation during most of work d)	king 16l	b. Kind of Business	/Industry
than	Completed	Elementary/Secondary (0·12)	College (1-4or 5+)		DO NOT use retired SEWIFE			OWN HO	ME
and Mental Hygis is marked other eumatic event, II	To Be	17. Father's Name (First, Middle, Last) HOWARD		BECK		KATIE	e (First, Middle, Mai		STEIN
h and 7 is m treum		19a. Informant's Name/Relationship (GERSHON NEY / SC					ral Route Number, C		
f Health item 27 i		20a. Method of Disposition		b. Place of Dispo			FLUSHING,	c. Location - City or	
nent of int: If its iny or o		1 X Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specif			matory`or other plac F HFRRFW	CEM. 1/14	1/2004	RAI TIM	ORE, MD
Department of I		21. Signature of Funeral Service Licer		22	2. Name and Addre	ss of Facility SC)L LEVINSO ROAD - PI	N & BROS	., INC.
nysician Medical xaminer		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a cor	Myo	cardic	1 0	avchou	·	Approximate Interval Between Onset and Death
physicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor	ete					Years
te has been signed by the attending I age 2 should be detached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pri 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy □ Other <i>(specify)</i> _	у		23d. Date of de Month	livery Day Year
n signed b	by	Part II. Other significant conditions of	contributing to death but not	t resulting in the u	nderlying cause giv	ven in Part I.			o the cause of death?
ate has been s page 2 should	ompleted						24a. Was an autopsy performed	d? prior to death?	utopsy findings availa completion of cause of
certificate ector, pag	Bec	25. Was case referred to medical examiner?					th (Check only one)		
this certificated and director,	၉	1 ☐ Yes 2 ☐ No		2 ER/Outpatier		4 Nursing no	ome 5 Residenc		ecify)
After	Certification:	27. Manne of Death 1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b			M 1 🗆	rk? Yes 2 No	28d. Describe how		Lund Courte Normhou
	Certif	4 Homicide determined	building, etc. (Sp	pecify)	reet, factory, office		28f. Location (Stree City or Town, S	State)	
in Line		29a. Certifier 1 Certifying Pt (Check only 2 Medical Exar	nysician: To the best of my miner: On the basis of examiner and manner stated.	knowledge, deat mination and/or in	h occurred at the tir vestigation, in my o	me, date and place, ppinion, death occur	and due to the caus red at the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)
nours afte nerel Dir	edica	one)	2.10.112.1110.1210.01						
in Line	Medical	29b. Signature and Internation			29c. Licens	se number	29d.	. Date signed (Mon	th, Day, Year)
nours afte nerel Dir	Medica	one)), MD	(Item 23a) (Type	DOC	56418	5. 50	Date signed (Mon	14,200

			_ For			and / Dep	artmen	t of H	ealth an	d Mental H		6	1 0000
			1 - State Registrar			Ce	rtificat	e of l	Death		Reg. N	200	
н	Physic	an	Decedent's Name (First, Mi							2. Date of D	eath Da	ay Year	
	/Medi	cal	MANIBEN NARAN 4a. Fecility Name (If not institu				4h Chi	Tour or	l continue of C	Januar			
1	Examir	ıer	LAUREL REGIONA				LAU		Location of D	eatn		c. County of Dea RINCE GE	
-	Funeral		5. Social Security Number	6. Sex	7. Age (In)	rs. last birthday,	If Under	1 Year	if Under 24				rthplece (State or Foreign ountry)
	Director		213-25-5398	1 □ M 200	F	82 Yrs.	Months	Days	Hours N	02/02/	Эву, Үвөг 1921	IND	OUNTRY)
	pu k		Usual Residence of Decedent 10a, State 10b, Cou	201	100	City, Town or L	nantina						
	Aaryla Febo	5	MD HOWA	•			ocation						10d. Inside City Limits 1 ☐ Yes 2 1 No
	tha h	Director	10e. Street and Number	עא	L	AUREL	10f. Zip	Code			10a C	itizen of What C	
	3a or		9225 HOMESTRET	CH COURT				0723			109.0	MIZON OF WHILE O	outiny :
	72 hours after death with the Maryland netural', or tems 23a or 28a-f ehow distal Extant werthust be tradified at	Funeral	11. Marital Status	12. Was	Decedent Ever is d Forces?	n U.S. 13.			spanic Origin	? (Specify Yes or Nuerto Rican, etc.)	10-	14. Race - Am	
36	or Ite	y Fu	1 Never Married 2 N	arried 1 TY	es 2 XNo		1 ☐ Yes		Specify:	uerto Hican, etc.)		Black, Whi	
Ö	hours ural',	d by	3 X Widowed 4 □ Divord	ed Year	or Dates:							Specify: AS	IAN-INDIAN
15	in 72	ojete	(Specify only hig	ent's Education hest grade complet		(Give	dent's Usua kind of wo DO NOT us	rk done o	uring most of	working	16b. h	Kind of Business	/Industry
212	d within 72 hours affigions. If then "natural", or the Medical Exam	Completed	Elementary/Secondary (0-12 5) Colle	ge (1-4or 5+)		MAKER				OWN	HOME	
þ	a fila Hyg othe	Bec	17. Father's Name (First, Midd	e. Last)					18. Mother's	Name (First, Middl	e, Maidei	n Sumame)	
ylaı		To	CHOTTABHAI MA	RGABHAI I	PATEL				DAHIBI	EN CHOTTA	BHAI	PATEL	
Maryland 21215-0036	and and le m		19a. Informant's Name/Relation		1					Rural Route Num			
ď	1 and Haalth em 27 other tr		VIJAY N. PATE	L, SON	200	9225 D. Place of Dispo			ICH CT,	LAUREL,			
Jor.	ages or of		20a. Method of Disposition 1 Burial 2 Crematic		rom State	cometery, cre 1t-Wash	matory or o	ther place		Date / 1 - / 2 - 0 - /		ocation - City or	
Baltimore,	artman prrant injury		* 4 ☐ Donation 5 ☐ Other 21. Signatute of Funeral Servi		Da					15/2004		REL, MA	
Ba	permit. Pagas 1 and Department of Haalti Important: If Item 2: any injury or other t		De Stackan	7000	Molas	50 7	601 C	ander	Coming I	Fleck Fun	eral	Home,	Inc.
Pi			23a. Part1. Enter the disease shock, or heart failure. L	2000			er the mod	e of dying	such as care	diac or respiratory	aure arrest,	1. Mary	land 20707 Approximate
10	Physician		Immediate Cause (Final disease or condition		on each line. RONARY A								Interval Between Onset and Death
1	/Medical		resulting in death)		to (or as a cons		TOLAS	£					YEARS
	Examiner	_	Sequentially list conditions.	b									
	si ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due	to (or as a cons	sequence of):							
	ba exacuted ician and burial-transif	xan	that initiated events resulting in death) Last	c. Due	to (or as a cons	sequence of):							
760,	eath certificate ba exacuted attending physician and for use as the burial-transif	calE											
68	g phy as the			0.									
Вох	th cert endin	N/UE	IF FEMALE: 23b. Was decedent pregnant		outcome of pre-		Ectopic pri					23d. Date of del	livery
	e deal	sicis	in the past 12 months? 1 ☐ Yes 2X No	4 □ P	regnant at time o		Other (spe					Month	Day Year
P.0	that the de ad by the a detached t	Physician/Med	9 Unknown							00 0:4			
ds,	og ga	by	Part II. Other significant cond DIABETES	tions contributing	to death but not i	resulting in the u	nderiying ca	ause give	n in Part I.				the cause of death?
Records,	w requir been si should	Completed					~			-		Z 100 3 F1	
Rec	has ge 2 a	mpi	HYPERLIPIDEMI	<u>A</u>						- 24a. Was	psy	prior to o	topsy findings available completion of cause of
Vital	in: Ti ficate or, pa	e Co	25. Was case referred to medi	ral							ormed? XXNo	1 ☐ Yes	2 X No
	Attending Physician: r death. ector: After this certific. by the funeral director,	To B	examiner?		☐ Inpatient 2	□ EB/Outpatier	1 3 DO	Othe		Death (Check only g Home 5 Res		s 🗆 00 to 1 (0 to 1	
100	g Phy ter thi neral (27. Manner of Death	28a. D.	ate of Injury Month, Day Year,	28b. Time of		8c. Injury Work	at	28d. Describe			ciry)
Sio	endir sath. or: Af he fur	atic	2	stigation	norm, buy rous,	Injury	М		es 2 □No				
Division of	or Att	Certification:	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	mined 209. Pi	lace of Injury · Atuilding, etc. (Spe	t home, farm, str icify)	eet, factory.	, office		28f. Location (Street an wn, State	nd Number or Ru	ıral Route Number,
	Hospital		20a Carrier 197 Carrier										
	To the Hospital or Attending Physician: The within 24 hours after death, within 24 hours after death, To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier 1 X Certifier (Check only one) 1 Medic	ring Physician: To al Exeminer: On the	the best of my k le basis of exami nanner stated.	ination and/or in	occurred a estigation,	at the time in my op	e, date and pla nion, death o	ace, and due to the courred at the time,	cause(s)	and manner as place, and due	stated. to the cause(s)
	To the within 2 To the compfel	Me	29b. Signature and title of parti		t stated.		29c.	. License	number		29d. Dat	te signed (Monti	h, Day, Year)
)			415	sotta	Poni	>	D	2318	1			ary 13,	
	h		30. Name and address of person	n who completed o	ause of death (I	tem 23a) (Type,	Print)						
	J		R. G. Bhojraj,		Gorman	Ave. #T	-1, La	aure.	l, Mary	land 207	07		
	Sta Registr		31. Date filed (Month, Day, Yea	ur) 33	Registrar's Sig	nature	a the		•				187
	riegisti	£1.	10N 1 6	2004		Section of the sectio	W. F. A.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Papania **Physician** anuak atricia /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Himore 1+4 N/A If Under 1 Year I tf Under 24 Hrs. Birthptace (State or Foreign Country) 8. Date of Birth (Month, Day, Yeer) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 ☐ M 2 🔀 F Yrs. **Director** April 16,1957 Maryland 216-68-7042 46 Usual Residence of Decedent deeth with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or iteme 23a or 28a-f show other traumatic event, the Medical Examination relations 1 ☐ Yes 2 ☑ No Directo Dundalk Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7817 Harold Road 21222 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: ģ 3 Widowed 4 Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Etementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Operment of Health and Mental Hygiens Important: if item 27 is marked other than eny injury or other traumatic event, If all pincs. 12 Years Restaurant Manager Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Howard Phillip Troyer Joyce Lorraine Mitchell 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. James Allen Papania 7817 Harold Road Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Holly Hill Mem. Gdns. 1/19/200 Middle River, Md `4 □Donation 5 ☑Other (Specify) Entombment 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, 21. Signature of Funeral Service Licensee 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final **Physician** bronculal obstruction NEEKS disease or condition resulting in death) /Medical Due to (or as e consequence of): **Examiner** Lung cancer 1 months Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury Due to (or us a consequence of). Examiner The law requires that the death certificate be executed the burial-transit that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 █ No Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by should be detac Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Nonknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 Yes 2**X**N0 Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No 2 ER/Outpatient 3 DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending 1 Natural Injury 5 Pending after death.

Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funeral D 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) January 14, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tower 110, Dectors Lounge 600 North Woife Street Baltimore Manyland

DHMH 17 Rev 1/2001

State Registrar Lauren Marie Averett

JAN 1 6 2004

31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

			i icase i	State of Mandand						
			For State	State of Maryland	•	tificate of L		_	200	1. 00000
			Registrar		Cel	lineate of L	Jean	2. Date of Death	g. No U U	3. Time of Death
	Physicia	ın	Decedent's Name (First, Middle, Last)		٥.			Month	Day Year	13.16 M
	/Medic	al .	4a. Facility Name (If not institution, give	Robinso	n	4b. City, Town, or	Location of Deat	January	4c. County of Dea	th Jispin
	Examin	er				•	altimore	. /	N/	
			Bon Secours Hospi 5. Social Security Number 6. Sec		t birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Birth		
	Funeral Director			M 20F 80	Yrs.	Months Days	Hours Min.	Mar. 29,	^{Уеаг)} 1923 Ма	thplace (State or Foreign ountry) aryland
			Usual Residence of Decedent							
	ylan how		10a. State 10b. County	10c. City, 7	Town or Lo	cation				10d. Inside City Limits 1X Yes 2 □ No
	Ba-fs	cto	MD N/A			Baltin	nore			
	or 28	Director	10e. Street and Number			10f. Zip Code			g. Citizen of What Co	
	ours after death with the Maryland rat', or tems 23a or 28a-f show Examinar must be notified at		413 Furrow Street				1223		United Sta	
		Funeral	Tr. Marital Olaido	12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (S n, Mexican, Puer	to Rican, etc.)	14. Race - Ame Black, Whi	
30	s aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1		1□Yes 2🗓 No	Specify:		Specify:	White
15-0036	filed within 72 hours after Hygiene. Ither than "natural", or Ite sht, II to McCoal Examina		15. Decedent's Edu		16a. Dece	dent's Usual Occupa	ation	1	6b. Kind of Business	/Industry
Ċ	in 72	plet	(Specify only highest grad	e completed)	(Give life.	kind of work done of DO NOT use retired	turing most of wo)	rking		
7	iene iene	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Homemake	er	1	Own Ho	ome
9	illed Hygie other	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle, M	aiden Sumame)	
<u>a</u>	Ald be	일	William Stolzenba	ıch			Clara	Shrank		
Maryland 21	2 should and Men is marke sumatic		19a. Informant's Name/Relationship (Ty	pe, Print)		•			City or Town, State,	Zip Code)
	12 E E		Michael Robinson	Son			el Rd.,	Parkton,		
Baltimore,	ges 1 and t of Healt if item 2 or other		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ F	20b. Plac	ce of Dispo	sition (Name of matory or other place Ce	θ)	Date 2	Oc. Location - City or	Town, State
Ĕ	Pages nent of ant: If it		'4 □ Bonation 5 □ Other (Specify)		iona]	Cemeter	y 1-1		Baltimore	
a	permit. Pag Department Important: any injury o		21. Signature of Funeral Service Licens	of the	22	2. Name and Address	ss of FacilitAmb	rose Fune	ral Home,	Inc.
m	89 6 8 9		(Cohline)	10 Mett Ma					butus, MD	T .
			23a. Part1. Enter the disease, or composhock, or heart failure. List only o	ications that caused the death. ne cause on each line.	Do not ent	er the mode of dying	g, such as cardia	c or respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	. Mefastu	tre	Brea	5T C	ancu		Oriset and Death
	/Medical		resulting in death)	Due to (or as a conseque	nce of):	11	1	(0		
	Examiner		Sequentially list conditions	Congesti	ne	Tla	4) 7	Jacker	e erded Vos	
	ש ש	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	nce of):	ato.	000	Tiz a	a. 1. T. 1.	- G. N-
	acute Ind trans	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conseque	me and	arun	Scar	ave ce	uaco Oos	cure isro.
60,	ite be executed iysician and ne burial-transit		Togating in douti, and	Die to (or as a conseque	rice or,					
687	cate to ohysic the to	dical	•	d						
	ding see as	/Me	IF FEMALE:	23c. If yes, outcome of pregnance	ev				23d. Date of de	divery
Box	ath c	lan	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea	eath 3	Ectopic pregnancy Other (specify)			Month	Day Year
o.	the de	yslc	1 □ Yes 2 □ No 9 □ Unknown	9□Unknown	5					
Δ.	Attending Physician: The law requires that the death certificat redath. r death. ector: After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the	by Physician/Med	Part II. Other significant conditions co	ntributing to death but not result	ing in the u	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute t	o the cause of death?
Records,	uires sign d be							1 □ Yes	s 2 No 3 P	robably 4 Unknown
Š	v requestion	Completed						24a. Was an	24b. Were a	utopsy findings available
ĕ	has has	dm						autopsy perform	ed? death?	utopsy findings available completion of cause of
Vital	n: Th ficate	င္ပ	25. Was case referred to medical				26 Place of Do	ath (Check only one	PNo 1 □ Yes	s 2 No
	sicia certi	8	evaminer?	Hospital: 1 ☑ Inpatient 2 ☐ El	R/Outpaties	nt 3 DOA Oth	or.		nce 6 Other (Spe	acify)
Division of	Phy or this oral d	To It	27. Manner of Death	28a. Date of Injury 2	8b. Time o			28d. Describe how		
O	ding th: Afte	tion	1-☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		Yes 2□No			
<u> S </u>	Atter r dea ector by the	ifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom	ne, farm, st	reet, factory, office		28f. Location (Str. City or Town,	eet and Number or R	lural Route Number,
á	al or afte	Certification:	4 Hottlicide	building, etc. (Specify)				ony or roun,	olato)	
/	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying Phy	sician: To the best of my knowl iner: On the basis of examination	iedge, deat	h occurred at the tin	ne, date and plac	e, and due to the ca	use(s) and manner a	s stated.
	the Hin 24 in 24 the Figure 1	Medical	one)	and manner stated.	or and or it					
	To the within 2. To the to complet	2	29b. Signature and title of certifier	5 MM 2	Zus	29c. Licens	e number イスカス (29	d. Date signed (Mon	tn, Day, Year)
			Prejust 1	10000	7			23	anuar	4 11, 2004
	(/)		30. Name and address of person who c	empleted cause of death (Item)	23a) (Type	Print)	BON .	SFROM	lanuar PRS F	DSDITAL
			31. Date filed (Month, Day, Year)	32. Register's Signatu	Ire -			12000	1-5	- SP///
	Sta Registi			2004 December 2004	13	South !				

			1 - For State Registrar	State of Maryland	d / Depa			Mental Hygi	ene g. No. 200	4 00903
	Physici		1. Decedent's Name (First, Middle, Las	Kom to				2. Date of Death Month	-	
	/Medio Examin		4a. Facility Name (If not institution, give				or Location of Death	JANUAYY	4c. County of De	ath
	Funeral Director		5. Social Security Number 214 05 4646 1 Usual Residence of Decedent	_ 24	st birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth	Year) 9. B	irthplace (State or Foreign Country)
	Maryland a-f ahow	tor	10a. State 10b. County	10c. City,	Dvn or Loc	4				10d. Inside City Limits 1 2 Yes 2 No
	th with the 23s or 28	ai Dire	10e. Street and Number 7939 Wise	Ave		10f. Zip Code 21	222		Dg. Citizen of What (States
036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Ptygiene. ortant: if item 27 is marked other than "natural", or Itema 23e or 28e-f ahow injury or other traumatic event, the Madical Examinational Le maillied at injury or other traumatic event, the Madical Examinational Le maillied at 8.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates:	1	Vas Decedent of Yes, specify Cut	Hispanic Origin? (S pan, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - An Black, Wr Specify:	nerican Indian, lite, etc.
21215-0036	d within 72 ho piene. r than "natur ine Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		(Give I	ent's Usual Occu kind of work done OO NOT use retire	pation during most of wor ad)	rking	6b. Kind of Busines	andustry Jorked
Maryland 2	should be filed ind Mental Hygie marked other umatic event, III	To Be C	17. Father's Name (First, Middle, Last) PASQVALE	Romito			A	ne (First, Middle, M	aiden Sumame)	1,
	1 and 2 sho Health and Iom 27 is ma		19a. Informant's Nam lationship (1 12	19b. Mailin	Address (Stree		DVHdA K	City or Town, State,	Zip Code) 21222
Baltimore,	permit. Pages 1 Department of He Important: If iten any injury or oth once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	ace of Dispos metery, crem VITN	sition (Name of atory or other pla Cremat	1 50 50 10	1ATY 14	oc. Location - City of Baltimore	Mary land
Balt	permit. Page Department Important: if any injury or once.		21. Signature of Funeral Service Licen	See		Name and Addr MARILY T	METAL HO	me of Di	mdalk, for	21222
	Physician /Medical		23a. Part1. Enter the disease, or come shock, or heart failure. List only of mmediate Cause (Final disease or condition resulting in death)	a. Due to (or as a conseque	Do not ente	ir the mode of dy	leart	Discus	et,	Approximate Interval Between Onset and Death
,092	ate be executed hysician and he burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conseque c. Due to (or as a conseque d.		rsis				
P.O. Box 68	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnand 1 Live birth 2 Fetal of 4 Pregnant at time of dead 9 Unknown	death 3 🗌	Ectopic pregnanc Other (specify)	у		23d. Date of do	alivery Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions of	ontributing to death but not result	ting in the un	derlying cause gi	ven in Part I.			to the cause of death? Probably 4 Unknown
Il Records,	: The law rec cate has bee page 2 shou	Completed						24a. Was an autopsy perform	ed? prior to death?	autopsy findings available completion of cause of
Vital	Phyaician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospitaf:		Ot		th (Check only one		
of	Attending Physic death. actor: After this by the funeral did	ation: To	1 Yes IPNo 27. Mann of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of fnjury (Month, Day Year)	R/Outpatient 28b. Time of Injury	28c. Inju	4 Nursing H	ome 5 ☐ Resider 28d. Describe how	ice 6 □ Other (Sp v in∤ury occurred	ecify)
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filted in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)		et, factory, office		28f. Location (Stre City or Town,	eet and Number or F State)	Rural Route Number,
	To the Hospital or A within 24 hours after to the Funeral Dirac completely filled in by	edical	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best of my knowl niner: On the basis of examination and manner stated.	rledge, death on and/or inv	occurred at the t estigation, in my	ime, date and place opinion, death occu	, and due to the cau rred at the time, dat	use(s) and manner a le and place, and du	s stated. e to the cause(s)
)	To the To the Comple	Me	29b. Signature and title of certifier	0 12	u 1)	29c. Licen			d. Date signed (Mon	
	Y)		30. Name and address of person who did not to the second s	completed cause of death (Item 2	23a) (Type, F	Print) S. E	ELLWood	AUE PS	AL TO, W	004 1021224
	Sta Registr	_	31. Date filed (Month, Day, Year)	32 Registrar's Signatu	11.0	100				

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Marylan		artment of rtificate of			iene2001	00904
	Dhorist		1. Decedent's Name (First, Middle, Last)				^	2. Date of Deatl	Day Yee	3. Time of Death
	Physici: /Medic		Lela				Roser	January		
	Examin		4a. Fecility Name (If not institution, give s				or Location of Dea	ath	4c. County of De	
				yview Medical C			nore Cit	4	Bultimore	
	Funeral		5, Social Security Number 6. Sex	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Yea Months Days		n. (Month, Day,		irthplace (State or Foreign Country)
	Director		219-28-3076 Usual Residence of Decedent	73	115.			April 1	0,1930	Maryland
	and and		10a. State 10b. County	10c. Cit	y, Town or Lo	cation			<u> </u>	10d. Inside City Limits
	Mary f sho	ō	Mareri and D-1	h :						1 ☐ Yes 2 ⊠ No
	the 1	Director	Maryland Bal 10e. Street and Number	timore		10f. Zip Code		Dundalk	og. Citizen of What (Country?
	3a or		4126 Eder Road				21222		mait a c	4 - 4
	ms 2	Funeral		2. Was Decedent Ever in U.	.S. 13.1	Was Decedent of		Specify Yes or No- into Rican, etc.)		nerican Indian,
20	or iter	귤	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No				erto Rican, etc.)	Black, Wh	nite, etc.
8	hours after death with the Maryland tural; or ttems 23a or 28a-f show al Examinat must be notified at	by	3√ Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2√2 No	Specify:		Specify:	White
2	be filed within 72 hours after death with the Marylan it all thygiene. del hygiene.	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	(Give	dent's Usual Occu	e during most of w	orkina 1	6b. Kind of Busines	s/Industry
2	filed within 72 Hygiene. other than "nal ent, me wedle	ldu	Elementary/Secondary (0-12)	Cotlege (1-4or 5+)	life.	DO NOT use retir	ed)			
2	filed wi Hygien Sther th ent, the		12 Years			Secretar	+		Cleric	al
ב	tal H	Be	17. Father's Name (First, Middle, Last)				18. Mothers Na	ame (First, Middle, N	laiden Surname)	
3	should be filed ind Mental Hygi marked other umatic event, I	7o	William Mirven Ka					garet Pear		
Maryland 21215-0036			19a. Informant's Name/Relationship (Typ. Karen S. Moreland			ng Address <i>(Stree</i> Jeannet		Rural Route Number,		
	thealth them 27 i		20a. Method of Disposition			sition (Name of	te Ave.	Dundalk,	Maryiana Oc. Location - City of	21222
altimore,	Pages nent of h int: If ite		M⊠Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	emetery, crer	natory or other pla	´ I			or rown, State
Ħ	t. Pag rtment rtant: I		Other (Specify)	_				y 1/16/200	04 Rose	dale, MD
Ba	permit. Pages Department of Important: If it eny injury or once.		21. Signature of Funeral Service License	(0	/// D	. Me and Addr uda – Ruck	Funeral	Home of I	Dundalk,	Inc.
			23a. Part1. Enter the disease, or complic	rations that caused the death				oundalk, M		21222 Approximate
ä			shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	n: Daylor on	er the mode or dy	ing, such as cardi	ac or respiratory arre	51,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Respirator		ilure				12 hours
	Examiner		1	Due to (or as a consequence)						4 000
2		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	USTIVET uence of):	ve primo	nary an	sease		Tougs
1	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Acute Ren	al fai	dure				BURDKS
ń	exec in an	Еха	resulting in death) Last	Due to (or as a consequ						3 60 64 13
8760	cate be executed physicien and the burial-transit	dlcal	€ d							
9	tifica ng ph as th	ed								
Вох	death certifica e attending ph id for use as ti	Physician/Me	230. Was decedent pregnant	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal		Ectopic pregnanc	cv		23d. Date of d	
	0 00 0	Cla	in the past 12 months? 1 ☐ Yes 2 🗷 No	4☐ Pregnant at time of de 9☐ Unknown		Other (specify)	~ <i>y</i>		Month	Day Year
о. О	The law requires that the de ite has been signed by the a page 2 should be detached	hy	9 Unknown							
ś	gned gned	by F	Part II. Other significant conditions con	tributing to death but not resi	ulting in the u	nderlying cause g	iven in Part I.	23e. Did toba	acco use contribute	to the cause of death?
D C	en si ould l	per	Company artery	disease				1 🗆 Yes	s 2□No 3□F	Probably 4 Mnknown
Vital Records,	law reas be	Completed						24a. Was an autopsy		autopsy findings available o completion of cause of
ř	The ate har page	mo;						perform	ed? death? Mo 1 ☐ Ye	
Ita	ien: ortifica ctor,	Be	25. Was case referred to medical examiner?				26. Place of De	eath (Check only one		
<u>-</u>	Physicien: The lav this certificate has al director, page 2	10	1 □ Yes 2 No	ospital: t Cinpatient 2	ER/Outpatien	t 3 DOA	ther: 4 Nursing	Home 5 ☐ Resider	ice 6 Other (Sp	ecify)
0	ng Pl	ü	27. Manner of Death 1 ★Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	ury at ork?	28d. Describe how	w injury occurred	
<u>s</u>	ttendi death. ctor: A r the fu	cati	2 Accident investigation			M 1]Yes 2 □No			
Division of	I or Attending Phater death. Director: After th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str	eet, factory, office)	28f. Location (Stre City or Town,	eet and Number or F State)	Rural Route Number,
	Hospital or Attending Physicien: 44 hours after death. Funeral Director: After this certific tely filled in by the funeral director,		One One Winner and Transferred	ļ						
	To the Hospital or At within 24 hours after of the Funeral Directompletely filled in by	edical	29a. Certifier 1 □Cartifying Phys (Check only 2 □ Medical Examin	ician: To the best of my kno- er: On the basis of examina- and manner stated.	wledge, death tion and/or inv	occurred at the treatment occurred at the tr	ome, date and place opinion, death occ	e, and due to the car curred at the time, da	use(s) and manner a te and place, and du	as stated. ue to the cause(s)
	within 2 To the complet	Mec	29b. Signature and title of certifier	and manner stated.		29c. Licen	isa number	29	d. Date signed (Mor	nth, Day, Year)
	+ 3 F 8		- N OT	- Moderal Date			5-000	-	-	
1	X		30. Name and address of person who col	unleted cause of death (!	2321 /7:				Danuary	
	U		John Name. The	e Johns lipkins	theo; to	1. 600 No.	th Wolfe &	treet Boltin	ore Marila	and 21287
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Signa	ture			· con porting	7,	
			1881 1 2 2007	Ka A	Co de	72				

		•	1 - For State Registrar	State of Maryland / Depa	artment of Health and rtificate of Death		ene 2004 00905
			Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
	Physici /Medio		Darrell Gene Roo	S		January	5, 2004 5:00 PM M
15	Examir		4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, or Location of Deat	h	4c. County of Death
			11307 Wycombe Pa		Glenn Dale	T (Prince George's
	Funeral Director		525-54-5557	M 2 F 7. Age (In yrs. last birthday)	Months Days Hours Min.		9. Birthplace (State or Foreign Colorado
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "netural", or Items 23e or 28e-f show any figury or other traumatic event, the Medical Enamerer must be notified at ance.	eral Director	Usual Residence of Decedent	rk Lane 2. Was Decedent Ever in U.S. 13.			10d. Inside City Limits 1 □ Yes 2 ☒ No 1. Citizen of What Country? USA 14. Race - American Indian,
21215-0036	nin 72 hours after n *natural', or ite	Completed by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade	1 Yes, Give Year or Dates: ation completed) 16a. Dece (Give	If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☐ No Specify: dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	16	Black, White, etc. Specify: white the Kind of Business/Industry unk
212	ed with giene er thai	Com	Elementary/Secondary (0-12)	College (1-4or 5+) 5+ compt	iter scientist		
land	ild be filk lental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, Last) Harold Frederic	k Roos		ne <i>(First, Middl</i> e, <i>Ma</i> Gertrude	
Maryland	id 2 shouth and N		19a. Informant's Name/Relationship (Ty) Elizabeth Crensh		ng Address <i>(Street and Number or Ri</i>)7 Wycombe Park L	ural Route Number, C ane Glenn	City or Town, State, Zip Code) Dale, MD 20769
Baltimore,	Pages 1 an hent of Heal int: If Item 2 iry or other		20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	20b. Place of Dispo cemetery, crei	osition (Name of matory or other place)	Date 20	c. Location - City or Town, State
Balti	permit. Departminents imports any inju		21. Signature of Euneral Service License ROna	åde Director St	Cate Anatomy Board altimore, MD 2120		altimore Street
31	Physician /Medical		23a. Part1. Enter the disease, or complishock, on heart failure. List only on immediate Cause (Final disease or condition resulting in death)		er the mode of dying, such as cardial		* Onset and Death
8760,	cate be executed physician and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of);			
.O. Box 6	The law requires that the death certificate ate been signed by the attending phy ate be sould be detached for use as the	Physiclan/Medical	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
٩.	puires that n signed b	Ď	Part II. Other significant conditions con	tributing to death but not resulting in the u	nderlying cause given in Part I.		cco use contribute to the cause of death?
Division of Vital Records,	: The law require cate has been si, page 2 should t	Completed				24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
<u> </u>	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	ospital:	Othor	ath (Check only one)	
on of	fing Ph	tlon: To	1 Yes No 27. Manner of Death Natural 5 Pending 2 Accident investigation	1 ☐ fnpatient 2 ☐ ER/Outpatier 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	11 3 DOA 4 Nursing F	28d. Describe how	ee 6 Other (Specify) injury occurred
Divisi	al or Attend after death I Director: d in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	at and Number or Rural Route Number, State)
	To the Hospital or Al within 24 hours after of To the Funeral Direct completely filled in by	edical C	29a. Certifier Continue Physics (Check only one)	ician: To the best of my knowled e deather: On the basis of examination and/or in and manner stated.	h occurred at the time, date and last vestigation, in my opinion, death occu	, and due to the daw irred at the time, date	ea(s) and in a mer as stated and place, and due to the cause(s)
)	To th withir To th compl	Me	29b. Signature and title of certifier MMMM	amy	29c. License number DYY STY		Date signed (Month, Day, Year)
			30. Name and address of person who co	mpleted cause of death (Item 23a) (Type, MD SU28 Ruf-LM) 32 Registrar's Signature	Print) é Hrvy suite 134	Paradena	MD 21/22
	Sta Registi	-	31. Date filed (Month, Day, Year)	32 Registrar's Signature	de		

Part Part				State of Maryland / Department of Health and N State Certificate of Death		iene 2004	00906
Secretary Company Co				Marie A Sochurek	Jan. 12	4 200 4 Year	3. Time of Death
Use of Part Part		Funeral	er	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.		Harlord	place (State or Foreign
190 Mailing Address Street and Number or Rural Route, Number of Rural Route, Number o			tor	the state of the s	IMUKUK 13	17/2 14/01	0d. Inside City Limits 1 □ Yes 2 🗷 No
190 Mailing Address Street and Number or Rural Route, Number of Rural Route, Number o		eath with the	eral Direc	2907 CONROY Ct. Apt D 21234		USA	
190 Mailing Address Street and Number or Rural Route, Number of Rural Route, Number o	9036	nours after duret, or Item	by	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Armed Forces? If Yes, specify Cuban, Mexican, Puèrio 1 Yes 2 No Specify:		Black, White,	etc. Le
190 Mailing Address Street and Number or Rural Route, Number of Rural Route, Number o	21215-	ed within 72 h ygiene. her than "nati it, the Mulica	Complete	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+)	ing	home	dustry
20. Method of Disposition (Name In State 1 and Date 2 a	ıryland	ed la be	Be	Michael C. Funk Elizab	eth Fu	NKe	Code)
Do to to the significant conditions contributing to death but not resulting in the underlying cause given in Part I. Control Contro		les 1 and 2 of Health a if item 27 is or other tre		AN HONY SOCHUER SR. 9018 SOUTH HILL RI 20a. Method of Disposition 1 & Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name bif cermetery, crematory or other place) South Hill Ri Cermetery, crematory or other place)	Balty	MOLE MD	21234
Sequentially list conditions, a possible of the property of th	Baltim	Pa nen nen ury		*4 Donation & Other (Specify) (SARAWS OF FAMILY 1	ANS FUL	Lekal Chap	4D 1234
The continue of the continue o	•	/Medical		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a.	or respiratory arre	est,	Interval Between
Female: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No No 3 Probably 4 Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23c. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23c. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23c. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23c. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23c. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23c. Did tobacco use contribute to the cause of death? 1 Yes 2 No 24c. Did to be contributed to the cause of death? 1 Yes 2 No 24c. Did tobacco use contribute to the cause of death? 1 Yes 2 No 24c. Did to be contributed to the cause of death? 1 Yes 2 No 24c. Did to be contributed to the cause of death? 1 Yes 2 No 24c. Did to be contributed to the cause of death? 1 Yes 2 No 24c. Did to be contributed to the cause of death? 1 Yes 2 No 24c. Did to be contributed to the cause of death? 1 Yes 2 No 24c. Did to be contributed to the cause of death? 1 Yes 2 No 24c. Did to be contributed to the caus	760,	te be executed ysician and ne burial-transit		that initiated events c.	xation, 8	hom oil	
25. Was case referred to medical examiner? 1 Yes 2 No No patient 2 ER/Outpatient 3 DOA Cher: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manper of Death Yes 2 No No patient 2 ER/Outpatient 3 DOA Cher: 4 Nursing Home 5 Residence 6 Other (Specify) 28. Place of Death (Check only one) 28. Place of Death (Check only one) 28. Place of Death (Check only one) 28. Place of Death (Check only one) 28. Place of Death (Check only one) 28. Place of Death (Check only one) 28. Place of Death (Check only one) 28. Place of Injury 28. Plac	ARIG.	the death certifica by the attending ph ached for use as th	hysician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 2 4 7 9 12 4 14 15			
25. Was case referred to medical examiner? 1 Yes 2 No No patient 2 ER/Outpatient 3 DOA Cher: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manper of Death Yes 2 No No patient 2 ER/Outpatient 3 DOA Cher: 4 Nursing Home 5 Residence 6 Other (Specify) 28. Place of Death (Check only one) 28. Place of Death (Check only one) 28. Place of Death (Check only one) 28. Place of Death (Check only one) 28. Place of Death (Check only one) 28. Place of Death (Check only one) 28. Place of Death (Check only one) 28. Place of Injury 28. Plac	5,	equires that en signed t	Ď	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		1	
The second of th	m œ				autopsy perform	prior to conded?	npletion of cause of
28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 28f. Location (Street and Number or Rural Route Number)	7 5	Phyer this ral die	2	examiner? 1	me 5 Resider	nce 6 □Other (Specify)
G. Z. B. T. Co. Contilled Distriction T. d.	Sco	i gift o	Certifical	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Stre City or Town,	eet and Number or Rural , State)	l Route Number,
29a. Certifier Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier (29c. License number) 29c. License number (29d. Date signed (Month, Day, Year)	M	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	Medical	(Check only 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurr and manner stated.	red at the time, dat	te and place, and due to	the cause(s)
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of gerson wird confidence cause of death (Item 23a) (Type, Print)		T WILL		► Willard P mos D000\$54	5	anumy 14	2004
State Registrar 31. Date filed (Month, Day, Year) JAN 1 6 2004 32. Registrar's Signifure			_	Willard & Amoss 2303 Below Re	7 Falls	ston, Mel	2104+

			For State Registrar	State of Mary		epartment of H C <i>ertificate of L</i>		1ental Hygie Req		00907
			1. Decedent's Name (First, Middle, Last,			· · · · · · · · · · · · · · · · · · ·		2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		DEVONNA	STAN	NOT			January	14,2004	10:10AM
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of Deat	h
			Bon Secours Hos			Baltim			N/A	
	Funeral Director		216-96-5194	- X	yrs. last birth	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y May 20, 1	9. Birt 969 M	hplace (State or Foreign puntry) D
	and *		Usual Residence of Decedent 10a, State 10b. County	100	c. City, Town	or Location				10d. Inside City Limits
	Aaryla f sho	5	MD N/A	_		imore				1⊠Yes 2 □ No
	the 1	Director	10e. Street and Number		Daic	10f. Zip Code		10g	. Citizen of What Co	untry?
	3a or	<u>-</u>	2308 Winchester	St. Apt.	A	2121	6	Ţ	J.S.A.	
	death ms 2	Funerai	11. Marital Status	12. Was Decedent Ever Armed Forces?		13. Was Decedent of Hi If Yes, specify Cuba			14. Race - Ame	
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural," or Items 23s or 28s-f show aumatic event, the Madical Examiner must be natified at	þ	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2X No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:	ricall, etc.)	Specify: B1	
2	72 ho	sted	15. Decedent's Edu (Specify only highest grad	(cation	16a. C	Decedent's Usual Occupa	ation during most of work	rina 16	b. Kind of Business/	Industry
21	ithin Jan M	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	—	ife. DO NOT use retired)			
2	led w lygier her th	S			N/A		10. Mathada Nam	N/		
DE	e d fa	Be	17. Father's Name (First, Middle, Last) Ralph Stanton					e (First, Middle, Mai	iden Surname)	
Ĕ	should ind Men s marke umatic	ို	19a. Informant's Name/Relationship (T)	vne Print)	19h J	Mailing Address (Street a	Mary J		ity or Town State 2	7in Code)
Ma	s 1 and 2 should of Health and Men item 27 is marke other traumatic		Ralph Stanton -							
	Heal Heal tem 2		20a. Method of Disposition		Ob. Place of D	2 Hunting Disposition (Name of	COIL DI.	Date 200	c. Location - City or	Town, State
Ē			1 ☑ Burial 2 ☐ Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)			crematory or other place ional Cem		/04 La	aurel, M	D
Baltimore,	permit. Page Department Important: Il any injury o		21. Signature of Fureral Service Licens			22. Name and Addres	s of Facility Nu	tter Fur	neral Ho	mes, Inc.
ñ	Per Per Suppose		> Prayon Miller	Ä		2501 Gwyn	ns Fall	s Pkwy.	Balto.,	MD 21216
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only o	lications that caused the ne cause on each line.	death. Do no	t enter the mode of dyin	g, such as cardiac	or respiratory arrest		Approximate Interval Between
	Physi ci an		Immediate Cause (Final disease or condition	SEPS	sis					SH hrs
	/Medical Examiner		resulting in death)	Due to (or as a cor	nsequence of): 5 hA=//	TTY	9		
	Examine:	_	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a con	5076-	S MECC	1	ے		
	led nsit	nine	cause. Enter Underlying Cause (Disease or injury	DIE 10 (01 454 COI	A L	Trsuza	i cen (7.		
	xecul and al-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or as a cor	nsequence of	Insun				
68760	ficate be executed g physician and is the burial-transit			Sever	W	ORBID	OBES	1+4.		
		ledicai	2.5							
Вох	h cert endin	an/M	230. Was decedent pregnant	23c. If yes, outcome of pr 1 Live birth 2 □	regnancy Fetal death	3 □Ectopic pregnancy			23d. Date of deli	
B	The law requires that the death certifule has been signed by the attending the has a sage 2 should be detached for use a.e.	Physician/M	in the past 12 months? 1 □ Yes 2 □No 9 □ Unknown	4☐Pregnant at time 9☐Unknown		5 Other (specify)			Month	Day Year
о. О.	hat the	Ph)	Part II. Other significant conditions co	ntributing to death but no	ot resulting in t	he underlying cause give	an in Part I	23e. Did tobac	co use contribute to	the cause of death?
Division of Vital Records,	uires t signe Id be	d by			•			1 ☐ Yes	2 No 3 Pr	obably 4 \underset Unknown
Ö	w requires been si should t	iete					-	24a. Was an	24b. Were au	topsy findings available completion of cause of
Re	The lav te has age 2	Completed						autopsy performed 1 ☐ Yes 2 ☑	dath?	completion of cause of 2 No
ta		Be C	25. Was case referred to medical				28. Place of Deat	h (Check only one)	110 100	2
<u>_</u>	Attending Physician: r death. ector: After this certificaby the funeral director, i	ToE	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 npatient	2 ☐ ER/Outp	atient 3 DOA Othe	er: 4 🗆 Nursing Ho	me 5 Residenc	e 6 ⊡Other (Spec	cify)
0	ng Pl		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	ar) 28b. Tir	ury Worl		28d. Describe how	injury occurred	
<u>s</u> io	tendi feath. for: A	cati	2 Accident investigation 3 Suicide 6 Could not be		***		Yes 2 No	Opt Leasting (Ct.		
\leq	To the Hologial or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the tuneral director.	Certification:	4 Homicide determined	building, etc. (S		n, street, factory, office		28f. Location (Stree City or Town, S	state)	rai Houte Number,
_	Pours neral	al C	29a. Certifier 1 ☐ Certifying Phy	sician: To the best of my	y knowledge,	death occurred at the tim	ne, date and place,	and due to the caus	se(s) and manner as	stated.
1	ne Ho	edical	(Check only 2 Medical Exami	iner: On the basis of exa and manner stated.	mination and	or investigation, in my or	oinion, death occur	red at the time, date	and place, and due	to the cause(s)
V	To the Comp	ž	29b. Signature and title of certifier			29c. License	number	29d.	Date signed (Month	h, Day, Year)
			R. M. Shah	M-D.		W19	8331	. 50	enuary	14,2004.
	h		29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 30. Name and address of person who one 31. Date filed (Month, Day, Year)	mpleted cause of death HOSPITA	(Item 23a) (T	ype, Print) Ods V/EST	Baltim	ore st:	Baltimo	88.MD.
	Sta Registr	te ar	31. Date filed (Month, Day, Year) JAN 1 6 2004	32. Registrar's S	Signature					
	3			A. C. C. C. C. C. C. C. C. C. C. C. C. C.	2	All reprise				

			_ For	epartment of Health and M Certificate of Death		ene 2001	00908
111			Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic	-	Francis Henry Suhrie		January	9 2004	2:00 a M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	th
			8244 New Cut Road	Severn		Anne Ar	rundel
	Funeral	1	5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Months Days Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Bir	thplace (State or Foreign ountry)
	Director		200-05-4684	.	Month, Day, Y	1918 Per	nsylvania
	pur *	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of	r Location		· <u> </u>	10d. Inside City Limits
	•ho	5					1 ☐ Yes 2 X No
	Z8e-f	Director	MD Anne Arunde1 Crow 10e. Street and Number	nsville	100	2. Citizen of What Co	puntry?
	with		1454 Fairfield Loop Road	21032		USA	
	death with the Maryland ms 23a or 28e-f ehow	Funerai		13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	
_	r iten	F	Armed Forces? 1 Never Married 2 Married 1 Ma		Rican, etc.)	Black, Whit	
0000	urs a	ρχ	3 Midowed 4 Divorced If Yes, Give WWII	1 ☐ Yes 2 No Specify:		Specity:	White
ה ה	2 ho	ted	15. Decedent's Education 16a. D. (Specify only highest grade completed) (C	ecedent's Usual Occupation Give kind of work done during most of work	ring 16	b. Kind of Business	/Industry
<u>''</u>	thin 7	ple	Elementary/Secondary (0-12) College (1-4or 5+)	fe. DO NOT use retired)	9		
7	ed wi	Completed		ehouseman		Oil Compa	any
and	d oth	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma	uiden Sumame)	
<u>Z</u>	Men Merke Marke	은	Henry Suhrie	Mary			
Ja	2 sh and is m			failing Address (Street and Number or Run			Zip Code)
a)	1 and 1ealth am 27			44 New Cut Road, Se isposition (Name of		C. Location - City or	Town State
Ď	if it		Burial 2 Cremation 3 Removal from State cemetery,	crematory or other place)			
банттог	it. Partment		*4 □Donation 5 □Other (Specify) Glen H 21. Signature of Funeral Service Licensee	aven Cemetery 1/12 22. Name and Address of Facility	/2004 6	len Burni	e, MD
g	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is ansked other than "natural; or items 23a or 28e-f show Importent: If item 27 is ansked other than "natural; or items and item in a late in cititied at one injury or other traumatic event, the Moulcal Exactinating an one.		Dotail & Mell	Hardesty Funeral 12 Ridgely Avenue			401
			23a. Part1. Enter the disease, of complications that caused the death. Do not				Approximate
	Discontinuo		shock, or heart failure. List only one cause on each tine. Immediate Cause (Final				Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) Due to (or as a consequence of)	ru monu			1 week
	Examiner						
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				
	cuted nd ransi	Examiner	Cause (Disease or injury that initiated events c.				
Ď,	e exe ien ar urial-t		resulting in death) Last Due to (or as a consequence of)	•			
9/90	cate be executed physicien and the burial-transit	dical	d				
Ď X	death certific e attending p id for use as	Med	IF FEMALE: 23c. If yes, outcome of pregnancy				
X Q Q	ath c	lan	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of de Month	Day Year
o.	wrequires that the death certific been signed by the attending p should be detached for use as	Physician/Me	1 Yes 2 No 9 Unknown	5 Other (specify)			
7.	requires that the een signed by th hould be detache		Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did toba	cco use contribute to	o the cause of death?
ds,	uires sign ld be	d by	Perseberal Unsular Disease	Demente	1 ☐ Yes	2 □ No 3 □ P	robably 4 🗷 Unknown
် လ	w req beer shou	lete	7.07		24a. Was an	24b. Were a	utopsy findings available
Vital Hecord	The law cate has b	Completed	Sivelle		autopsy	ed? death?	utopsy findings available completion of cause of
ē		ပိ	25. Was case referred to medical	26 Place of Deal	1 Yes 2th th (Check only one)	Mo 1 ☐ Yes	s 2 /8 ,No
	S 10	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outp.	Other	ome 5 Residen	ce 6 DOther (Spe	sons dence
0	g Phys er this eral di		27. Manner of Death 28a. Date of Injury 28b. Tin (Month, Day Year) Inju		28d. Describe how		77,00
ਠੁ	Mending P death. ctor: After i	atlo	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
DIVISION	r Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
	oital o urs af rral D						
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier 1 Check only one) 1 Medical Examiner: On the basis of examination and/one) and manner stated.				
	To the I within 2 To the I complet	Mec	29b. Signature and title of centrier	29c. License number	290	d. Date signed (Mon	th, Day, Year)
ı	⊢ s ⊢ ŏ		> Poch MA	D38958		1/15/200	1.
	10		30. Name and address of person who completed cause of death (Item 23a) (Ty	(no Print)		שפוניון	7
	•		Datet Sind Sidly 1413 H	nnoholy boad #	106 00	lenton N	1D 21113
	Sta	ite	31. Date(filed (Month, Day, Year)) 32. Registrar's Signature	Ancelles			,,
	Registr	rar	THN TO COON				

			1 - For State Registrer	State of M	arylar	nd / Depa		t of H	ealth a				20) () L ₄	00909
	Physic /Medi	al	1. Decedent's Name (First, Middle Edith	Marg	garet		Szyn				2. Date of De Month Januar	y 8	2	Year 004	3. Time of Death 2:30 p M
	Examir	ier	4e. Fecility Name (If not institution 1461 Washingt 5. Social Security Number	on Avenue		last birthday) Yrs.	4b. City,	Sev	ern If Under 2 Hours		8. Date of Bir (Month, Da	th	nne	9. Birthp	ide1 plece (State or Foreign
	Director)r	236-22-6913 Usual Residence of Decedent 10a. State 10b. County MD Anne	Arundel		ty, Town or Lo					April	7, 1	914		t Virginia 10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	a within 72 hours after death with the Maryland jiene. r then "natural", or Items 23a or 28a-1 show Itra Medical Examiner must be notified at	Funeral Director	10e. Street and Number 1461 Washingto 11. Marital Status		Ever in U		10f. Zip	211		gin? (Spe	city Yes or No		g. Citizen of What Country? USA 14. Race - American Indian,		
21215-0036	72 hours after "natural", or It	by	1 Never Married XXMarri 3 Widowed 4 Divorced 15. Decedent (Specify only highes	ied 1 ☐ Yes 2 X If Yes, Give Year or Dates:	No	16a. Deceo	∏Yes 2	No I Occupa	Specify: tion uring most				Specif	ck, White,	White
	othe	Be Completed	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Inches Programme 1 december 1)	College (1-4or:	Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) Minnie Shanklyn										
, Maryland	and 2 should be ealth and Mental m 27 is marked oner trsumatic ever	10	John Reynolds 19a. Informant's Name/Relations! Walter F. Szync	•		1461	Wash	ingt	nd Number	r or Rura enue	Route Number	er, City o			
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other trsumatic ev 900.9.		20a. Method of Disposition XXBurial 2 □ Cremation 4 □ Donation 5 □ Other (S) 21. Signature of Funeral Service in	pecify)	1	Place of Disposemetery, cremetery, cremetery.	en Cei Name and	nete: Address	ry 1	/13/	DELIVER CONTRACT	Gle		City or To	
	Enysician	V (9	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	complications that caused	I the deat		IZ Ric	dge L	y Ave	nue,	•	olis rest,	, MI	2140	O1 Approximate Interval Between Onset and Death
8760,	/Medical Examiner system and he burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as Due to (or as Due to (or as Due to (or as d.	eb a conseq terr	ioscl	as a	Ia ni	1 0	ace	iden	*			
P.O. Box 6	w requires that the death certificat been signed by the attending phy should be detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Feta	I death 3	Ectopic pre Other (spe					2	3d. Dat Mo	te of delive	ry Day Year
	The law requires that the ate has been signed by the page 2 should be detache		Part II. Other significant condition	ns contributing to death b	ut not res	ulting in the un	derlying ca	use giver	n in Part I.		23e. Did to		_		e cause of death?
ital Rec		Be Completed	25. Was case referred to medical	24a. Was an autopsy findings prior to completion of clearly the second of the second						npletion of cause of					
Division of Vital Records,	ing Phys n. After this tuneral dir	P	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investig	ation	ry	ER/Outpatient 28b. Time of Injury		c. Injury a Work?	at at	2	e 5 N Resid 8d. Describe h)
Divis	Plospital or Attend 24 hours after death Funeral Director: etely filled in by the	al Certification:	3 Suicide 6 Could n determi	ned 286. Place of Inju-	of my kno	y) wledge death	Occurred at	the time	. date and	nlace a	City or Tow	n, State)	and ===		Route Number,
	To the Hospital or within 24 hours afte To the Funeral Directory completely filled in It	Medical	(Check only 2 Medical E	xaminer: On the basis of and manner sta	examina	tion and/or invi	estigation, i	License	nion, death	occurre	d at the time, d	late and	place, a	(Month, D	the cause(s)
	5		30. Name Maddress of person v			23a) (Type, F		ad a	0den	itan	MD 3	1043	3	09	770000000000000000000000000000000000000
4	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra			2015	, ,	C (3×1)		,,=				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day рм WILLIAM SIEMEK 13,2004 12 JAN. /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MANORCARE TOWSON TOWS OIN

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or rows (Month, Day, Year) | 7. Country)

SEPT - 10, 1928 MARY AND TOWSON 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1**∑**M 2□F Yrs. Director 75 218-26-8899 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show s 23a or 28e-f show Director MD. 1 TYes 2 No N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1821 FLEET STREET 21231 Funera 12. Was Decedent Ever in U.S. Armed Forces? or Items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. the Medical Examinati Black, White, etc. 72 hours after 1 ☐ Yes 2 TNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ≥ Specify: 3 Widowed 4 Divorced WHITE "neturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) BUSINESS OWNER MEAT MARKET permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth eny injury or other treumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOSEPH J. SIEMEK VERONICA YUREK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DANIEL G. SIEMEK/SON 7613 OLD HARFORD ROAD, BALTIMORE, MD. 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State *4 ☐ Donation 5 ☐ Other (Specify) STANISLAUS CEM. 1/17/04 BALTIMORE, MARYLAND ST. 21. Signature of Funeral Service Licensee Name and Address of Facility
ILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD. 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Due to (or as a consequen Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a co quence of) Examine and Il-transit The law requires that the death certificate be executed that initiated events resulting in death) Last physician are the burial-Due to (or as a c Records, P.O. Box 68760. by Physiclan/Medical attending I IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown signed by d be detact Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably **#X**Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an has certificate 1 ☐ Yes 20 No Division of Vital Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Thomicide within 24 hours a 12 Sertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner/stated. 29a. Certifier Medical To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number em 23a) (Type, Print) 0 41 31. Date filed (Month, Day, Y 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrer	State of M		epartment of Certificate or		Mental Hygie	21101	00911
	Physici	an	1. Decedent's Name (First, Middle, La.		FONADD	COLILIA	D.T.7	2. Date of Death Month	Day Year	3. Time of Death
	/Medi Examir		ARNO 4a. Facility Name (If not institution, giv.		LEONARD	SCHWA	or Location of Dear		4 2004 4c. County of Dea	
П	Lxamii	iei		L OF BAL	TIMORE	1	ORE CITY		40. Godiny of Boa	N/A
	Funeral Director		5. Social Security Number 6. S 219-16-8282	ex 7. Ag	e (In yrs. last birti 78	rs. If Under 1 Year Months Day:			9. Bin 25	thplace (State or Foreign ountry) MD
	pu *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town			1000		
	Maryla f sho	o.		IMORE		ALTIMORE				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	r 28a-	irect	10e. Street and Number	THUKE	<u> </u>	10f. Zip Code		10g.	Citizen of What Co	
	23a o	raiD	11 SLADE AVENUE	#705			21208			U.S.A.
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Madical Examinate must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ◯ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 NYes 2 1 If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☑ No		Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit	wican Indian, e, etc. WHITE
8	2 hour	ted	15. Decedent's Ec	ducation	16a. I	Decedent's Usual Occi	pation	16b	. Kind of Business/	
21215-0036	vithin 7 ne. han "n	Completed	(Specify only highest gra	College (1-4or 5	i+)	Give kind of work done life. DO NOT use retir	i during most of wo ad)	rking		
	Hygier Hygier ther ti		17. Father's Name (First, Middle, Last)	4	OWI	NER	18 Mother's Na	me (First, Middle, Maid	ETAIL FUR	RNITURE
Maryland	fental fental rkad c	To Be	PHILLIP		SCHI	WARTZ	FLORE		on comand,	GOLDBERG
lary	2 shor		19a. Informant's Name/Relationship (ural Route Number, Cit		Zip Code)
	1 and Health em 27 ther tr		FRANCES SCHWARTZ 20a. Method of Disposition	/ WIFE	20h Diago of I	Diamonities (Alees - of	1	- BALTIMOI	RE, MD 21	
JOE.	Pages ent of ht: If it y or o		1 ABurial 2 □ Cremation 3 □ 4 □ Donation _5 □ Other (Specify		cemetery	HALOM MEMO			•	
Baltimore,	permit. I Departm Importar any inju		21. Signatura Funeral Service Lucy		, OHED SI	22. Name and Addr	ess of Facility S	OL LEVINSON	REISTERST N & BROS.	, INC.
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused	the death. Do no			ROAD - PII	CESVILLE,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	and the second second		ardial Inf	_			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):				Jay
		je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequence of).				
	icate be executed physician and s the burial-transif	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c						
58760,	sician a	al E	rooding in dodiny Eddi	Due to (or as	a consequence of):				
_	tificate ig phys as the	ledical		. d						
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetel death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	у		23d. Date of delin Month	very Day Year
S, D	ss that gned b	by PI	Part II. Other significant conditions co	ontributing to death be	at not resulting in t	he underlying cause g	ven in Part I.	23e. Did tobacci	o use contribute to	the cause of death?
ord	w require been sig should b	ted	Atrial Fibrillati	57				1 📝 Yes	2 □ No 3 □ Pro	bably 4 Unknown
Division of Vital Records,	sician: The law certificate has b rector, page 2 sl	Completed		,				24a. Was an autopsy performed? 1 Yes 2 1	prior to co	topsy findings available ompletion of cause of 20 No
<u> </u>	sician: Th certificate irector, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatie	-1 2 TED/O	ot no.		th Check onl one		
סו	ding Phys h. After this funeral dir	n: To	27. Manner of Death	28a. Date of Injur (Month, Day	v 28b. Tir	ne of 28c. Inju	4 Nursing n	ome 5 Residence 28d. Describe how in		ify)
Slor	Attendin death. ctor: Afi y the fur	catio	1 Matural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		7647		Yes 2 □ No			
Š	l or Atl after d Direct I in by	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc	iry - At home, farn . <i>(Specify)</i>	n, street, factory, office		28f. Location (Street: City or Town, Sta	and Number or Rui ite)	ral Route Number,
フ	To the Hospital or Attending Physician: whith 24 hours after death at this certificator. After this certificator has been been been been been at the funeral director.	Medical C	29a. Certifier 1 Certifying Phyone) 1 Medical Exam	ysicien: To the best of liner: On the basis of and manner sta	examination and/	death occurred at the ti or investigation, in my	me, date and place opinion, death occu	, and due to the cause rred at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)
	withi To t	Σ	29b. Signature and title of certifier			29c. Licen:	se number		ate signed (Month,	, Day, Year)
A	7)			026	Ja	nuary	14 2004
	U		30. Name and address of person who g	L. HONG	ath (Item 23a) (T	ype, Print) SINA	HOSPITA	L OF BA	ð	
	Sta		31. Date filed (Month, Dayr Year)		's Signature	Brook 5	17-31117	IL OF DA	r (Mules	
	Registr	ar	Soffice or a	di salah	M. Actor Serve	State of the state				

State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Edna M. Tracey-Weinreich Jan. 8 1:15 A 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Catonsville Commons Catonsville Baltimore 5. Social Security Number 8. Date of Birth (Month, Day, Nov. 12 Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Year 1 ☐ M 2🂢 F Months Hours Min. Yrs. Director 76 214-20-2915 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 ie marked other than "neturel", or items 23e or 28a-f show amy injury or other traumatic event, if a Medical Evantiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits X Yes 2 No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 West Conway Street, Apt. 1103 United States 21201 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White á 3 Widowed 4 Divorced Specify: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be 2 Wallace Homer Francis Lillian Doerr Francis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21853 19a. Informant's Name/Relationship (Type, Print) Kenneth C. Weinreich Stepson 10810 Perryhawkin Church Rd., Princess Anne, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 □ Cremation 3 □ Removal from State * 4 □ Donation 5 □ Other (Specify) Oak Lawn Cemetery 1-10-2004 Dundalk, MD 21. Signature of Funeral Service License 22. Name and Address of FacilityAmbrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) repras Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit physician and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal de. 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 1 ☐Yes 2 ₺ No 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ဩUnknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2. No 1 🗌 Yes 2 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4. Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 5 Pending М 2 Accident investigation 1 Tes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1£ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and eted cause of des h (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		For 1 = State Registrar	State	of Marylar		artmen rtificat			nd Me		ene 2	004	009	13
		Decedent's Name (First, Middle,	Last)						2	2. Date of Death			3. Time of Deat	th
Physici		Willia Baker	Toliver							Month January	Day 11, 2	Year 2004	4:15 P	М
/Medic Examir		4a. Facility Name (If not institution,	give street and no	ımber)		4b. City,	Town, or L	ocation of				ty of Death		
		Millennium Heal	Lth & Rel	nabilita	ition	For		shing			Pri	nce G	eorge's	
Funeral			3. Sex 1 □ M 2 🛣 F	7. Age (In yrs.		If Under Months	1 Year Days	If Under 24 Hours	Min	B. Date of Birth (Month, Day,)	/ear)	Cour	lace (State or Fore	eign
Director		721-14-5345	1 M 244F	93.	Yrs.				1	Aug. 16,	, 1910	Ŋ Vir	ginia	
pur *		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation				<u> </u>		1	0d. Inside City Lin	nits
faryla eho	5		0	Pau	+ 17aal	.	_						1 ☐ Yes 2 ☐	No
28a-	ect	MD Prince 10e. Street and Number	George's	FOI	t Wash	10f. Zip				10	g. Citizen of	What Coun	itry?	
with se or	ā	12021 Livingstor	Road			2	0744				USA			
d within 72 hours after death with the Maryland siene. Jene, rhan "naturel", or Iteme 23s or 28s-f show the Madical Examinat must be notified at	Funeral Director	11. Marital Status	12. Was Dec	cedent Ever in U	.S. 13.			panic Origi	in? (Speci	fy Yes or No- can, etc.)	14. Ra	ce - Americ		
r iter		1 ☐ Never Married 2 ☐ Marrie	Armed F	orces? 2 □ No iveX		_			Puerto Ri	can, etc.)		ack, White,	etc.	
ours a	by	3 X Widowed 4 ☐ Divorced	Year or I	NeX Dates:		1 ☐ Yes	2 (A NO	Specify:			Spec	<i>ту</i> : В.	lack	
72 hours aff naturel', or dical Exam	Completed	15. Decedent's (Specify only highest	Education grade completed)	(Give	dent's Usua kind of wo	k done du	on ring most o	of working	, 11	6b. Kind of	Business/Ind	dustry	
within lene. than "	npf	Elementary/Secondary (0-12)	1	(1-4or 5+)	life.	DO NOT us	e retired) maker				Oran	Home		
0 2 2 -		8	204)			Home			'e Namo /	First, Middle, Ma				
B la b	Be	17. Father's Name (First, Middle, L										1110/		
2 should be and Mental ie marked aumatic ev	2	Stephen S. Baker 19a. Informant's Name/Relationsh			10h Maili	na Address	/Street an			Ann Bro		state Zin	Codel	
nd 2 sl lith an 27 ie r r traur		Madie T. Muschet		ahter	1	8 Fri				ashingt				
1 an 1 an 1 an 1 an 1 an		20a. Method of Disposition	te bau	20b. F	Place of Dispe	sition /Nan	na of	- 1	Da			- City or To		
Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 🔲 Removal from	State	cemetery, cre			!		0.1	01:5.		77.5	
그른란중		21. Signature of Funeral Service L		1 Ke	d HIII	Ceme 2. Name an			1-17-	.04	CILIL	on roi	ge, VA	_
Depariment of the parameter of the param	1	Moral.	1100	ldo ?	V	N	icely	Fune	eral	Home fton Fo		574 077		
	1	23a. Part1. Inter the disease of shock, or heart failure. List of	perplications that	caused the deal	th. Do not en	ter the mod	e of dying,	such as ca	ardiac or	respiratory arres	t,	V.21. Z.11.	Approximate Interval Between	
Physician	,	Immediate Cause (Final disease or condition resulting in death)	CA	1)092	0	- 7	745	PA	TAK	1645		Λ	Onset and Death	
/Medical		resulting in death)	Due to	(or as a consec	quence of):		- 1			<u> </u>		-		
Examiner		Sequentially list conditions.	b											
D =	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consec	quence of):									
and trans	Examiner	that initiated events resulting in death) Last	c. Due to	o (or as a consec	ulence of):									
certificate be executed ding physician and use as the burial-transit				(0, 43 4 00, 300	(40,100 01).									
phys s the	dical		d											
eath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, or	utcome of pregn	ancy						23d. D	ate of delive	nry	
death cert te attendin ad for use	Physician/M	in the past 12 months? 1 □ Yes 2 ☒ No		birth 2 ☐ Feta nant at time of c		⊒Ectopic pr ⊒ Other <i>(sp</i>					N	lonth	Day Year	
at the de by the	hysi	9 Unknown	9□ Unk	nown										
g 2 2 9	by P	Part II. Dther significant condition	s contributing to	death but not res	sulting in the u	inderlying o	ause given	in Part I.		23e. Did toba	cco use co	ntribute to th	e cause of death	?
w require been sig should b										1 ☐ Yes	2 🗆 No	3 Prob	ably 4 □Unkno	own
law requires tas been signed as been signed.	ompleted									24a. Was an autopsy	24b	. Were auto	psy findings availa	able
The he had age	E									performe	ad? Ď No	death?		
sician: certifica irector, p	BeC	25. Was case referred to medical examiner?							of Death (Check only one,				
Physician: r this certific rral director,	2	1 ☐ Yes 2X No		Inpatient 2				4 CA INUIS	-	e 5 ☐ Residen			1)	
	on:	27. Manner of Death 1 X Natural 5 □ Pending		of Injury nth, Day Year)	28b. Time o Injury		8c. Injury a Work?			d. Describe how	injury occu	irred		
Attending r death. actor: After by the fune	catl	2 Accident investigation and accident and accident and accident and accident and accident and accident and accident and accident and accident and accident and accident and accident accident and accident acciden	ot bo	e of Injury - At h		M		es 2 N		f. Location (Stre	ot and Num	bor or Our	I Cauta Numbas	
	ertification;	4 Homicide determin		ding, etc. (Speci		ieel, iactor	, onice		20	City or Town,	State)	Der Or Fibra	THOUGH INGINIDES,	
Hospitel 24 hours a Funeral I tely filled	O	29a. Certifier 1X Certifying	Physician: To th	ne best of my kni	owledge, deat	h occurred	at the time	, date and	l place, an	d due to the car	ise(s) and n	nanner as si	ated.	
To the Hospitel o within 24 hours af To the Funeral D completely filled it	edical		xaminer: On the											
To the within 2 To the complet	Me	29b. Signature and title of certifier				%	. License	A	3		•	ed (Month,		
1		1///19		w	`) - (185	45	JX	AUUN	AY 1	2, 200	74
4		30. Name and address of person v	no completed car			Print)	120	10	1 177	JX	1/00	IC I	14 201-	~~
		F. WISOVILY	M.D-		0 6	الما	1100		NIZ	C W1	14181	u, W	W. 200	02
Sta Regist	ate rar	31. Date filed (Month, Day, Year) JAN 1 6 20		Registrar's Sign	ature	Service Control								

			1 - For State Registrar	State of	Marylar		artment o			nd Mental H	ygiene Reg. No	/ 11111	00911
			Decedent's Name (First, Middle, I	Last)						2. Date of C	eath		3. Time of Death
	Physici /Medi		Marion T. Travis	3						Month	Day	4 2004	1115 AM
	Examir		4a. Facility Name (If not institution, g	rive street and num	iber)		4b. City, Tow	n, or Loca	ation of [County of Dea	
			Union Memor	ial Hosp	ctal		Balt	inu	re		N/	Ά	
п	Funeral			. Sex 1 □ M 2 🛣 F	7. Age (In yrs.	last birthday)	If Under 1 Ye Months Da		Jnder 24 ours	Hrs. 8. Date of B	irth Day, Year)	9. Bir	thplace (State or Foreign
mg/s	Director		Usual Residence of Decedent			65 Yrs.				Mar 2			ylánd
	land		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10d. Inside City Limits
	Mary f sh	ō	MD N/A			timore							1Æ Yes 2 □ No
	28s	Director	10e. Street and Number		Dal	.crmore	10f. Zip Coo	ie			10a Citi	zen of What Co	nuntru?
	3a ol	<u></u>	455 Whitridge St	root			21218					ed Sta	•
	ms 2	Funeral	11. Marital Status	12. Was Dece	dent Ever in U		Was Decedent	of Hispan	ic Origin	? (Specify Yes or N		14. Rece - Ame	
9	within 72 hours after deeth with the Maryland ene. then "netural", or Items 23e or 28e-1 show te Medical Examinat must be retified at	Ē	1 Never Married 2 Married		2 🔀 No		t Yes, specify C	Suban, Me	exican, P	uerto Rican, etc.)		Black, Whit	e, etc.
င္တ	ral', c	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Da		ŀ	1□Yes 2🎇	No Sp	ecify:			Specify: Black	
21215-0036	72 h	Completed	15. Decedent's (Specify only highest of	Education		16a. Dece	dent's Usual Oc kind of work do	cupation	most of	Luorkina		nd of Business	/Industry
7	ithin sen	du	Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT use re	tired)	, most or	WORKING	Fac	tory	
7	ygier ygier it.		11			Labor	er						
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "netural", or Items 23a or 28a-f show any injury or other traumatic svent, If a Medical Examinar must be notified at Once.	Be	17. Father's Name (First, Middle, Las	st)				18. 1	Mother's	Name (First, Middle	a, Maiden	Sumame)	
<u>}</u>	i Meri Harke	L P	Neal Stepen							la Maddo			
ā	12 st and r		19a. Informant's Name/Relationship			7				r Rural Route Numi			
	l and lealth im 27		Mrs Florence Car	ter-Siste					Str	eet, Balt			
Baltimore,	Pages ment of H ant: If Ite		20a. Method of Disposition 1 28 Burial 2 Cremation 3	☐Removal from S		cemetery, cren	sition (Name of natory or other)	place)	i	Date Jan 22	20c. Lo	cation - City or	Town, State
Ë	t. Pa tmen tant: njury		`4 □ Donation 5 □ Other (Spec		Mo		on Ceme	-		2004	Balt	imore,	MD
<u>ब</u>	Deparenti Deparenti Importanti eny ir		21. Signature of Funeral Service Lice	ensee	10		. Name and Ad			ms Funera	l Ho	. D A	
	40 = 9 d		23a. Part. Enter the disease, or co	4.07	hand	2	818 Eas	t Ra	1.tim	ore Street	+ B	altimor	e, MD
	Physician and // // // // // // // // // // // // //	i Examiner	shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, and beautiful and and cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Hype Du to (o	r as a conseq	uence of): ns huc uence of):	tive Pu	Imc	naı	ry Disea	ક ૯		Approximate Interval Between Onset and Death
38760,	ate t hysic the b	dlcai		d									
Box (death certiff e attending id for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnanl in the past 12 menths? 1 ☐ Yes 2 ☐ Ho 9 ☐ Unknown		th 2 ☐ Fete nt at time of d	I death 3	Ectopic pregna Other (specify)				2	3d. Date of deli	very Day Year
<u> </u>	res that i		Part II. Other significant conditions	contributing to dea	th but not res	ulting in the un	deriving cause	given in P	Part I	23a. Did	obacco us	e contribute to	the cause of death?
Records,	faw requires that the as been signed by the 2 should be detache	d by									Yes 2□		1.7
ខ្ល	w require been signature	lete								04= 146=		0.45 144	
T	sician: The law certificate has l irector, page 2 s	ompleted										prior to c death?	topsy findings available ompletion of cause of
	an:] tifical for. p	e C	25. Was case referred to medical					20.0	Plane of I	1 Yes	2000	1 🗆 Yes	200
	Physician: this certificanal director.	0 B	examiner? 1 🗌 Yes 2 XNo	Hospital:	patient 2 🗆	ER/Outpatient	3□ DOA	John on		Death <i>(Check only</i> in general Home 5 Resi		T0# /0-	
	g Ph er th	n: T	27. Menger of Death	28a. Date of	Injury	28b. Time of	28c. In			28d. Describe			iry)
ō	Attending I death. ctor: After y the funer	atio	1 Natural 5 Pending 2 Accident investigation		Day Year)	Injury		Vork? ∐Yes :	2 🗆 No				
Division	Die c	ertification:	3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined	286. Place o	f Injury - At ho g, etc. <i>(Specif</i>)	ome, farm, stre	et, factory, offic	æ	*	28f. Location (City or To	Street and wn, State)	Number or Rui	ral Route Number,
	pspit hours mere y fille	a C	29a. Certifier 1 Certifying P	hysicien: To the b	est of my kno	wledge, death	occurred at the	time, dat	te and pla	ace, and due to the	cause(s) a	nd manner as	stated
	he Hos n 24 ho he Fun pletely	edical	(Check only 2 Medical Exa	miner: On the bas and manne	is or examinat	tion and/or inv	estigation, in my	y opinion,	death or	ccurred at the time,	date and p	lace, and due	to the cause(s)
	To the Hospitel of within 24 hours af To the Funerel D completely filled in	×	29b. Signature and title of certifier				29c. Lice	nse numb	ber		29d. Date	signed (Month,	Day, Year)
			Meschles	MO			ATA	438	940	D9	Jan	uary 1	4 3004
	B		30. Name and address of person who	completed cause	of death (Item	23a) (Type, F	Print)	, 00	, , ,	- 1	9	J-	.,
			30. Name and address of person who Catherine Meschles 31. Date filed (Month Day, Yazı)	: Union N	Temorie	d Hosp	ital; 20	1 =	Unive	ersity Park	Lway	Baltin	nore MD 2121
	Sta	e	31. Date filed (Month, Day, Year)	32. Reg	jistrar's Signa	ture					1,		

			For	State of Maryla		artment of H		-	ene 2001	00915
			Registrar 1. Decedent's Name (First, Middle, L	ast)		imouto of E		2. Date of Death		3. Time of Death
	Physici	an	Lillybel			Twigg		Month	Day Year 14,2004	9-05 D M
	/Medic		4a. Fecility Name (If not institution, g			4b. City, Town, or	Location of Deeth	January	4c. County of Deat	8:05 P ^M
	Examin	er								
			Dorchester Gen 5. Social Security Number 6.		s. last birthday)	Cambr If Under 1 Year	Idge If Under 24 Hrs.	8. Date of Birth	Dorche 9. Birt	ester hplece (State or Foreign
	Funeral Director		179-20-1926	1 M 2 F 77	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, NOV. 26.		ex. Pa
			Usuel Residence of Decedent					1000, 20,	1100	31177
	land		10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	Mary	ğ	MD Dorche	stee F	ISHING	Beck				1 ⊟Yes 2 □ No
	289 289	Je C	10e. Street and Number	37-24-		10f. Zip Code		10	g. Citizen of What Co	untry?
	with pa of	⊡	2743 HOOPERS	Island R.	1	216	34	1	715 A	
	72 hours after death with the Maryland Insturel; or Items 23a or 28s-f show disal Examinat must be notified at	by Funeral Director	11. Marital Status	12. Was Decedent Ever in	U.S. 13. 1	Was Decedent of His If Yes, specify Cubar		ecify Yes or No-	14. Race - Ame	
	ter of the control of	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No	- 1			Rican, etc.)	Black, White	e, etc.
5-0036	al', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify: W	41 TE
ŏ	2 hou	Completed	15. Decedent's		16a. Dece	dent's Usual Occupa	ition	1	6b. Kind of Business/	industry
_	n n Ned	ple	(Specify only highest of Elementary/Secondary (0-12)	rade completed) College (1-4or 5+)	life	kind of work done d DO NOT use retired,	uring most of work)	ing		
212	within piene. r than	E	//	College (1 401 57)	Ho	MEMAKER			OWN A	tomE
	illed I Hygir other	BeC	17. Father's Name (First, Middle, La	st)			18. Mother's Nam	e (First, Middle, M	laiden Sumame)	
a	ould be Mental arked c	ToB	WILBERT HE	WNER.			MABEI	1 SPRO	UT	
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Heelih and Mental Hygiene. If I tem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Madical Examinar must be notified at		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Street a	nd Number or Rur		City or Town, State, 2	Zip Code)
Š	and 2 leelth a m 27 is		HERMAN H. TWIGG	- HUSBAND	2743	HOOPERS.	Island A	d Fishin	of CREEK, 1	MD 21634
ē,	Heem Hem othe		20a. Method of Disposition	206	. Place of Dispo	sition (Name of matory of other place	1		c. Location - City or	Town, State
u 0	ages ant of it: If I		Burial 2 Cremation 3 4 Donation 5 Other (Spec		OE UNE	. //	py 1/1	9/14	VOE PA	
Baltimore	permit. Pages 1 and Department of Heelth Important: If Item 27 Inny injury or other tr pnca.		21. Signature of Funeral Service Lice		22	2. Name and Addres	s of Facility	1107) , , , , , ,	0
Ba	permit. Departr Importa any inji		Attalia K	Mille	1	4 Fleely	CH 10411	Mary St.	DA MASTOR	UN TA 17312
	- 6		23a. Perf1. Enter the disease, or co	mplications that caused the de	eath. Do not ent	er the mode of dying	such as cardiac	or respiratory arre	T	Approximate
			shock, or heart failure. List on Immediate Cause (Final	ly one cause on each line.	•	,		. ,		Interval Between Onset and Death
	Physician		disease or condition resulting in death)	a. Jeps	w					3 days
	/Medical Examiner		1	Due to (or 🎜 a cons	equence of):	*				371.
b		Ļ	Sequentially list conditions,	b. Due lo (or as a cons	comor of:	ua				- / ady
7	sit ad	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equence on).	-		100	-	27 days
	and I-tran	кап	that initiated events resulting in death) Last	c.	acuence of	maci	in	recu	do	1 alig
50,	cate be executed physicien and the burial-transit	Ü		80 110 1	/ /	1111	WILLA			-
8760	icate be ex physicien s the buria	dlcal		d. Jewa	ce.	peace	wa.			
9	death certific a attending pl d for use as t	Me	IF FEMALE:	22- 11						
Вох	ath co	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pred 1 ☐ Live birth 2 ☐ Fe	etal death 3	Ectopic pregnancy			23d. Date of deli	ivery Day Year
	the a	Sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregnant at time o 9 ☐ Unknown	f death 5	Other (specify)				Ĺ
P.O.	The law requires that the death certific thas been signed by the attending page 2 should be detached for use as	Completed by Physiclan/Me		a contract value as death but not	enutine in the	a daubica agus agus	n in Dark I	23a Did tob	acco use contribute to	the cause of death?
	igne bed	by	Part II. Other significant conditions	continuous g to death but not i	Class A	nderlying cause give	ni ili rai(i.			obably 4 Unknown
ord	w require been si should t	ted	cara	i jung	une	are		1 19:	5 2 C9410 5 FT	ODADIY 4 DOTINIOWII
Records,	as be	ple	periph	eral va	scul	en ais	lare	24a. Was an autopsy	prior to d	topsy findings available completion of cause of
	sician: The law certificate has b irector, page 2 s	ПO	V					perform 1 Yes 2	ed? death? □ No 1 ☐ Yes	2 PNo
of Vital	ian: rtificz stor, I	Be	25. Was case referred to medical examiner?				26. Place of Deat	h (Check only one)	
f \	ding Physician: h. Ater this certific funeral director,	70	1 Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatier	nt 3 DOA Othe	or: 4 Nursing Ho	ome 5 🗆 Resider	nce 6 Other (Spec	cify)
0			27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of Injury (Month, Day Year,	28b. Time of Injury	f 28c. Injury Work	at	28d. Describe hor	w injury occurred	
Division	Attending or death. ector: After by the fune	Certification:	2 ☐ Accident investigat	ion			res 2 □ No			
<u>Vis</u>	Atte	tific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		t home, farm, str	eet, factory, office		28f. Location (Str. City or Town,	eet and Number or Ru State)	ral Route Number,
Ö	el or s afte al Dir	Seri		5 g	,,,			2., 2		
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu			Physicien: To the best of my learnings: On the basis of exam						
	ne Ho n 24 ne Fu	Medical	one)	and manner stated.	mation and/or in	vestigation, in my of	minori, death occur	red at the time, da	te and place, and due	to the cause(s)
	with: To the	Σ	29b. Signature and title of certifier			29c. License	number	29	d. Date signed (Month	n, Day, Year)
	/		gatrinia	apan	un	HOO	5997	3	1/15/04	
			30. Name and address of person wh	o completed cause of death (I	tem 23a) (Type,				1 1	
			100 Biamb	w St Co	un bric	dal, m	0 2	1613		
E	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's S	nature	3	e			
	Regist		JA	N 1 6 2084 A	norther of	F 15.54	and the same of th			

			For	State of Maryla	nd / Department of	Health and M	lental Hygien	e2111	00916
		500	For State Registrar		Certificate of	Death	Reg. N	0.	00010
	Physicia	an.	1. Decedent's Name (First, Middle, Last)				2. Date of DeathMonth Da	ay Year	3. Time of Death
	/Medic		KEGIN	A B. L	URIGHT	and another of Donath	Jan 6	700G	1-10pm
A.	Examin	er	4a. Fecility Name (If not institution, give	street and number)	4b. City Town,	or Location of Death	44	c. County of Deeth	arre)
	r		5. Social Security Number 6. Sex	7. Age (In yrs	last birthday) If Under 1 Year	r If Under 24 Hrs.	8. Date of Birth (Month, Day, Year	9. Birthr	place (State or Foreign
9	Funeral Director		215-44-8502 10	M 200 F	Yrs. Months Days	Hours Min.	(Month, Day, Year	n) Cour	
3	2		Usuel Residence of Decedent 10a. State 10b. County	100 C	ity, Town or Location			1	Od. Inside City Limits
2	win the maryland a or 28a-f chow Les notified at	ž	333		DA OLA III				1 ☐ Yes 2 🛣 No
9	28a-f	ecto	10e. Street and Number	10Rt	10f. Zip Code	C	10a. C	itizen of What Cour	
\	3a of	Funeral Director	8800 waither	Rlud		21234		1)54	
1	ms 23	nera		12. Was Decedent Ever in U Armed Forces?			ecify Yes or No-	14. Race - Americ Black, White,	
9	or its		1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give	1 ☐ Yes 2 1 No		Tricari, Gio.,	Specify:),	•ic.
1700	n /z nours anter deam w "naturel", or items 23a edical Examiner mast h	d by	3 Widowed 4 □ Divorced	Year or Dates:	^		40	ω_I	1146.
1215-	n /2 n "nat	Completed	15. Decedent's Edu (Specify only highest grade	e completed)	16a. Decedent's Usual Dccu (Give kind of work done life. DO NOT use retin	apation e during most of work ed)	ing 166. I	Kind of Business/Ind	oustry
7 212	Hygiene. Hygiene. Ither then	ошь	Elementary/Secondary (0-12)	College (1-4or 5+)	Inspector	Supervis	sor F.	C.C.	
	other	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, Maide	n Surname)	
	z shoud be liled withit and Mental Hyglene. is marked other then aumatic event, Ing Mi	To E	Henry Me	locik		Anne	a Kari	vasek.	
	mi. Pages 1 and 2 should be jiled within 72 hours after death with the Maryla addressed in the first part Mental Hygiones addressed them 23a or 28a-f ehov orfain: It flem 27 is marked other then "naturel", or items 23a or 28a-f ehov injury or other traumatic event, the Madical Examiner mant be notified at injury or other traumatic event, the Madical Examiner mant be notified at g.	į,	19a. Informant's N me/Relationship (Ty	pe, Print)	19b. Mailing Address (Stree	at and Number or Run	al Route Number, City	or Town, State, Zip	Code)
3, 8	permit. Pages 1 and 3 Department of Health Important: If Item 27 eny injury or other tr pnca.		Henry Hottmo	(206	Place of Disposition (Name of	The second secon	Date 20c. I	Location - City or To	220
altimore	Pages 1 nent of H int: If ite iry or ot		20a. Method of D sposition 1 Ø Burial 2 ☐ Cremation 3 ☐ R		cemetery, crematory or other pl				
tir.	rtmer rtant njury		 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licers 	HO	14 Klacemer (ross of Facility - A		ALTIMOR	
Ba	Depa Impo eny ir	ļ, ,	Kin he die die	Zuventku	FUALLS EN	DE ON CH	APEL. 8500	MD ZI	
	F		23a. Part1. Enter the disease or complishock, or heart failure. Vist only or	ications that caused the de-	ith. Do not enter the mode of dy	ring, such as cardiac	or respiratory arrest,	JAN CECK	Approximate
	hysician		Immediate Cause (Final	Aciate	Myomordial	Info	ration		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a conse	quence q():	\\	TO CITOTI		-
	Examiner		Sequentially list conditions	Coronary	1 Hrtery L	rsease	1		
3	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	quence of):				
3	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):				
		cal E			4				
687	tificate ng phys as the			d					
×o	eath certifica attending ph for use as th	N/U	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr				23d. Date of delive	ery
m §	ne death the atte	icia	in the past 12 months?	4 Pregnant at time of				Month	Day Year
0. 3	that the death cer ed by the attendir detached for use	Phys	9 Unknown				1		
Division of Vital Records, P.O. Box	Attending Physician: The law requires that the death certifical death. action: After this certificate has been signed by the attending ph by the funeral director, page 2 should be detached for use as th	Completed by Physician/Med	Part II. Other significant conditions con PNEUMOTHO		sulting in the underlying cause g	iven in Part I.		use contribute to th	
orc	w requires been sign should be	eted	THEMITOTIC					^	
Jec	has t	mpi					24a. Was an autopsy performed?	prior to cor death?	psy findings available impletion of cause of
al	certificate rector, pag		25 W				1 Yes 2 N		2□ No
Xi.	ysician: The lis certificate hadirector, page	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Depatient 2	ER/Outpatient 3 □ DDA	ther	h (Check only one) ome 5 Residence	6 □Other (Specif	(1)
o	g Phys er this eral di	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Inje		28d. Describe how inju		7)
ion	ttending Ph death. ctor: After th the funeral	atio	1 Natural 5 Pending 2 Accident investigation	(MORBI, Day 19a1)		Yes 2□No			
ivis	r Atternation	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, street, factory, office	3	28f. Location (Street a City or Town, Stat	nd Number or Rura te)	l Route Number,
	ral Di	Cer	200	li di di di di di di di di di di di di di		,			
1	To the Hospital or Attency, within 24 hours after death To the Funeral Diractor: completely filled in by the	Medical	29a. Certifier 1 Certifying Physical Check only 2 Medical Exami	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, death occurred at the ation and/or investigation, in my	time, date and place, opinion, death occurr	and due to the cause(s red at the time, date an	 and manner as st d place, and due to 	ated. the cause(s)
	o the o the o the omple	Mec	29b. Signatura and title of certifier	and manner stated.	29c. Licer	nse number	29d. 🎞	ate signed (Month,	Day, Year)
	- 3 - ŏ		MILANDAM	T13 A C	0.0	005685)	12/2004	
	111		30. Name and address of person who co	THOMAS M.			N 10	10000	6112.200
There's	10		Dr. Abraham	Thomas C	1000 Franklir	Square.	Drive. Da	Itimore,	Md. 21237
	Sta Registr		31. Date filed (Month, Day, Yoar)	6 2004 Registrar's Sign	ature			,	

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician 30 2004 January /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deet Examiner mile If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Date of Birth Security Number **Funeral** Days Months 1 M 2□F 6010 219-50-Director permit. Peges 1 end 2 should be filed within 72 hours efter deeth with the Meryland Depertment of Heelth and Mentel Hyglene. Important: If Item 27 is marked other than "naturel", or items 23s or 28e-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County if item 27 is marked other than "nature!", or items 23s or 28e-f show or other traumatic event, the Medical Examiner must be notified at Yes 2□No Director 10g. Citizen of What Country? 10f. Zip Code 15H Ballou Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 2 Married 1 Never Married Black Baitimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Š 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) WOORKER (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Williams orraine 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State creenmount 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee MD 21217 alternore w. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner ete hes been signed by the ettending physicien end page 2 should be deteched for use as the burial-trensit The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Unknown 1 ☐ Yes 2 ☐ No 3 Probably þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? certificete hes 21 No 1 ☐ Yes 2 ☐ No 1 🗆 Yes or Attending Physicism: efter deeth. To the Nospital or Attending Physicisn: within 24 hours effer deeth.

To the Funeral Director: Affer this certifice completely filled in by the funeral director, i 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ဥ 2 No npatient 1 Tyes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Neturel 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3∏ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide A hours tertifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier who completed cause of death (Item 23a) (Type, Print) 301 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Les de s Registrar

DHMH 16 Rev 6/95

		For State	State of Man		ertment of Health			2001	00918
		Registrar 1. Decedent's Name (First, Middle, La	st)	007	imedie of bedi		Date of Death	. No.	3. Time of Death
Physicia		1/18/1/18.7	/	EINR	ETCH	5	Month	Day Year	1//30 - 44
/Medic Examin		4a. Fecility Name (If not institution, giv			4b. City, Town, or Location	on of Death		4c. County of Dea	4
LAGIIIII	e.	Mercy Men	(cal- (1)	nxer	BULTI	TMOY	LE	Balt	IMONE
Funeral		Social Security/Number 6. S	3.1	In yrs. last birthday)	If Under 1 Year If Und Months Days Hour	der 24 Hrs. 8.	Date of Birth (Month, Day, Y	9. Bi	rthplece (State or Foreign country)
Director		218-01-1036	M 2□F	83 Yrs.	Months Days Hou				ryland
pu .		Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or Lo	nation				10d. Inside City Limits
arylan show	ا ج			oc. Oily, Town of Lo	Cation				1 ⊠Yes 2 □ No
or 28a-f	Director	MD N	/A		Baltimore		100	. Citizen of What C	Tourster?
with a or	ក់								
eath	Funeral	1 West Conway Str	eet. Apt. 1		21201 Vas Decedent of Hispanic	Origin? (Specify		United St	
fler d	Fu	1 ☐ Never Married 2 ☐ Married	Armed Forces? tyTyYes 2 ☐ No if Yes, Give	li li	Yes, specify Cuban, Mexi	ican, Puerto Ric	an, etc.)	Black, Wh	
urs a	þ	3√Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1	∏Yes 2∭XNo <i>Spec</i>	cify:		Specify:	White
be filed within 72 hours after death with the Maryland be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f show event, the Madical Examinar must be notified at	Completed	15. Decedent's E (Specify only highest gro		16a. Deced	lent's Usual Occupation kind of work done during n	nost of working	16	b. Kind of Business	s/Industry
thin thin	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired)	nost of morning			
ed wi	Co	12		Supe	erintendent				uction
be fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name (First, Middle, Last			18. Mo	other's Name (F		•	
a y failed within 2 12. 2 should be filed within and Mental Hygiene. Is merked other than aumatic event, the Mental control of the M	입	Charles Adam Wein					Agusta		7.0 / 1
VICE ST IS IN ANCE		19a. Informant's Name/Relationship (g Address (Street and Nu				
ic, Mai yid		Kenneth C. Weinre		20b. Place of Dispos) Perryhawki: sition (Name of	n Unurci		c. Location - City o	
permit. Pages 1 and Department of Health Important: If Item 27 any injury or other trongate.		1 X Burial 2 ☐ Cremation 3	Removal from State	cemetery, cren	natory or other place)	1 1 -			
permit. Pages Department of Important: If it	1	4 ☐ Donation 5 ☐ Other (Special Service Lice		Oaklawn (Cemetery . Name and Address of Fa	1-17-2		undalk, M	
permit. Departimports Imports sny inj	1	adune D	DI DOLLA		328 Sulphur				
₩	,	23a Part1. Enter the disease, or com	plications that caused th						Approximate
Dhusisian		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	V 5000	+ toans	10 .00			Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. Due to (or as a c	consequence of):	1 250/Y	emi	151		MUNU
Examiner			MCSCI	1 XeVIC	1.50he	2200			Unikipina
	je.	Sequentially list conditions, if any, leading to immediate	Due to (or as a c	consequence of):		r rest			0.0.00000
cuted	Examlner	cause. Enter Underlying Cause (Disease or injury that initiated events	С.						
sician ar	EX	resulting in death) Last	Due to (or as a c	consequence of):					
Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	dical	•	_ d						
e as l	Mec	IF FEMALE:							
ath co	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2	Fetal death 3	Ectopic pregnancy			23d. Date of de Month	elivery Day Year
the de	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at tim 9 ☐ Unknown	ne or death 5	Other (specify)				
that the sed by detac	H.	Part II. Other significant conditions	contributing to death but r	not resulting in the ur	nderlying cause given in Pa	art I.	23e. Did toba	cco use contribute t	to the cause of death?
signe d be d	d by						1 ☐ Yes	2 □ No 3 1 B	Probably 4 Unknown
w requir been si	iete						24a. Was an	24h Were a	utonsy findings available
VICION: The lav certificate has rector, page 2	Completed						autopsy performe	d? death?	
in: Ti		25. Was case referred to medical			26 PI	lace of Death (C		No 1□Ye	s 2□No
vsicia s cert	To Be	examiner? Yes 2 No	Hospital: Oppatient	2 ER/Outpatien	Other			ce 6 ☐Other (Spe	ecify)
erath erath		27. Manner of Death	28a. Date of Injury (Month, Day Y	28b. Time of	28c. Injury at Work?			injury occurred	July)
ath. r: Afte	atlo	☐Matural 5 Pending 2 Accident investigation		(eer) Injury	M 1 Yes 2	2 □No			
DIVISION C BI or Attending P s after death. It Director: After t d in by the tunera	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc. (- At home, farm, stre (Specify)	eet, factory, office	28f.	Location (Stre	et and Number or F State)	Tural Route Number,
ital ol rs aft ral Di	Cer								
To the Hospital or Attending Physician: The law within 24 hours after deadth. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier 1 ☐ Certifying P. (Check only one) 1 ☐ Certifying P. 2 ☐ Medicel Exa	hysician: To the best of r miner: On the basis of ex and manner stated	camination and/or inv	n occurred at the time, date restigation, in my opinion,	e and place, and death occurred	l due to the cau at the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)
To the within 2 To the comple	Me	29b. Signature and title of certifier	and marinor states		29c. License numb	oer .	290	Date signed (Mon	th, Day, Year)
1		10 A 121	1	1	()		5	urun	7/3 20011
1		30. Name and address of person who	completed cause of deal	th (Item 23a) (Type,			11		, -009
		JULIAT BONACO	Im 301.	ST PAUL	PLACE	BAC	TIM	INE, MI	1 71205
Sta		31. Date filed (Month, Day, Year)	32. Registra	Signature	1000				
Regist	rar	IAN	1 6 2004	Latina At	STATE OF THE STATE				

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death **Physician** Helena C. January 15. 2004 Wieciech 2:22 AM /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Locetion of Deeth 4c. County of Death Examiner Baltimore Oak Crest Care Center Parkville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) March 29, 1922 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) Funeral Helenc Months Days Hours Min. 216-16-6256 Yrs. 81 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23s or 28s-f show traumstic event, the Madical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Maruland Baltimore Parkville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 8800 Walther Blud., Apt. 2305 21234 U.S.A. Funerai 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: White <u>م</u> 3 ☑ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore Citu Elementery/Secondary (0-12) College (1-4or 5+) Teacher Public Schools 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John S. Wisniewski Anna Н. Kocuan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Katherine Friesser (sister) 24 Bangert Avenue, Perry Hall. MD 21128 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Stanislaus Cem. 1/17/04 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Schimurick Function Homes 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or es a consequence of) Physician/Medicai Examiner attanding physician and for use as the bunal-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No þ 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Was en autopsy 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No or Attending Physician: ours after deeth. eral Director: After this certificatiled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes 2 No 27. Menn f Death 28e. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Vithin 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30 Name and ad ress of person who e Print) Marraga 00

State Registrar 31. Dete filed (Month, Day, Year)

32. Registra s Signature

		1 - State Registrar		ryland / Dep Ce	ertificate		F	Reg. No.	2001	
Dhamini		1. Decedent's Name (First, Middle, Las.	t)				2. Date of Dea Month	ath Day	Year	3. Time of Death
Physicia /Medic		Frances			Wrig	ht	Janua			9:55p.
Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Tov	wn, or Location of Dea	th	4c. C	ounty of Deat	th
		Holy Cross Hos	pital			er Spring			ontgor	
Funeral		5. Social Security Number 6. Se	7. Age	(In yrs. last birthda	Months D	ear if Under 24 Hrs ays Hours Min		h y. Ye <i>ar)</i>	9. Bir	thplace (State or Forei
Director		213-32-2102	7	74 Yrs.			04 08	3 29		VA
>	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location					10d. Inside City Limi
sho	-	Too. State								1 □ Yes 2 🛣 N
148	ctc	MD		Silver				10- CN-	en of What Co	
De D	吉	10e. Street and Number			10f. Zip Co	20910			J.S.A.	•
ital Hygiene. ad other than "natural", or itams 23a or 28a-f show avent, tra Mudical Examiner must be notified at	Funeral Director	9101 2nd Ave	10.14 515		Was Dander		Canada Van ar Na		I. Race - Ame	
Itam out	nu	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S.	If Yes, specify	t of Hispanic Origin? (Cuban, Mexican, Pue	rto Rican, etc.)	. '	Black, Whit	
ъ.	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2X No If Yes, Give Year or Dates:	'	1 ☐ Yes 2 🖸	KNo Specity:		S	Specify:	Black
lural En		15. Decedent's Ed		16a Dec	edent's Usuai C	occupation		16h Kind	d of Business	
ᄪ	Completed	(Specify only highest grad	de completed)	(Giv	e kind of work of DO NOT use r	fone during most of we retired)	orking	TOD: Turk	a or 20011000	
then then	E C	12th grade	College (1-4or 5+))	House			Pı	rivate	е
ther int.		17. Father's Name (First, Middle, Last)	ii d				ıme (First, Middle,			-
Mental arkad o atic ave) Be	George Scott				Mabel	R. Rich	nard		
and Mentalis marked sumatic av	ဥ	19a. Informant's Name/Relationship (7	vne Print)	19b. Ma	iling Address (S	treet and Number or F	lural Route Numbe	r. City or	Town, State,	Zip Code)
7 ts 1 trsu										
t of Health and Men If Item 27 is marks or other trsumatic		John Wright-Son 20a, Method of Disposition		20b. Place of Dis	position (Name	int_Lane,	Date	20c. Loca	ation - City or	Town, State
Department of H Important: If Ite any injury or of Once.	1	1 ☐ Burial 2X Cremation 3 ☐		I .		I	120101			
tant		`4 □ Donation 5 □ Other (Specify				ory Inc 1	./13/04	Bal	timore	e, Ma
Important in once.		21. Signature of Funeral Service Lice	100			Address of Facility F/H West				
25 4 0		/ Jala 10 10	uch		4300 Wa	abash Ave			e Md	21215
i.u.		29a. Part1. Enter the disease, or composition of the shock, or heart failure. List only of	dications that caused the caused the cause on each line	he death. Do not e).	inter the mode o	f dying, such as cardia	ic or respiratory ar	rest,	i	Approximate Interval Between Onset and Death
ysician		Immediate Cause (Final disease or condition	Sensi	s Syndro	ome					Days
Medical		resulting in death)	Due to (or as a	consequence of):						
aminer		Sequentially list conditions	b. Pneumo	onia						Days
-	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	·	consequence of):						
ransi	Examln	that initiated events	·	id Volv	ulus					Days
sicien and burial-transit		resulting in death) Last	Due to (or as a	consequence of):						
> W	cal		d							
attending physic I for use as the b	Physician/Medi									
endir use	5	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1□Live birth 2		B Ectopic pregr	nancy		23	d. Date of de	
e att	Cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at ti		Other (speci		· 		Month	Day Year
by the stached	hys	9 🗆 Unknown	9LI UNKNOWN			-				
igned l	by P	Part II. Other significant conditions of	ontributing to death but	not resulting in the	underlying caus	se given in Part I.	23e. Did to	obacco use	e contribute to	the cause of death?
n sig							101	/es 2□	No 3□Pi	robably 4 Unkno
s peen si should	Completed						24a. Was		24b. Were au	utopsy findings availa
page 2	Ĕ							rmed?	death?	completion of cause
certificet rector, pa	ပိ	25. Was case referred to medical				26 Place of De	1 ☐ Yes eath (Check only o	2 No	1 🗆 Yes	ZALNO
directo	o Be	examiner?	Hospital: 1 Inpatient	t 2 ER/Outpati	ient 3 DOA	Other	Home 5 ☐ Resid		Other (See	no.64)
± = =	 	27. Manner of Death	28a. Date of Injury			Injury at	28d. Describe h			city)
h. After funer	흔	1 XNatural 5 ☐ Pending	(Month, Day	Year) Injury		Work? 1 ☐ Yes 2 ☐ No				
deat ctor: / the	Ca	3 Suicide 6 Could not be		y - At home, farm,	street factory o		28f. Location (S	Street and	Number or Ri	ural Route Number,
مَ فِي	Certification;	4 Homicide determined	building, etc.	(Specify)		-	City or Tox		/ /	
		29a. Certifier 1 Certifying Ph	ysicien: To the best of	mu knowledge de	ath occurred at t	the time, date and place	e and due to the	callec(e) =	nd manner as	e stated
ours and eral Dii			niner: On the basis of e	examination and/or						
24 hours afte Funeral Dit tely filled in	ica		and manner state	eu.				29d Date	signed (Mont	
hin 24 hours after the Funeral Distributed in mpletely filled in	Medica	one)			200	ICARSA DUMBA?				h. Dav. Year
within 24 hours after To the Funeral Discompletely filled in	Medical	29b. Signature and title of certifier	adilize the	eddu Mi		cense number			_	h, Day, Year)
within 24 hours after death. To the Funeral Director: At completely filled in by the fur	Medica	29b. Signature and title of certifier	adulge A	eddy Mo					_	
within 24 hours after To the Funeral Discompletely filled in	Medica	29b. Signature any title of certifier 29b. Signature any title of certifier 30. Name and address of person who	complet cause of dea		e, Print)		s, Rock		_	

		For State Registrar	State of Maryland /	Depar Certi	tment of Herificate of L	ealth and M Death		iene 201	04 00921
Physic		1. Decedent's Name (First, Middle, Last)	Evangeline	1	White		2. Date of Dea Month		3. Time of Death p 12:05 M
/Med Exami		4e. Fecility Name (If not institution, give st Sinai Hospi	tal		Baltimo			4c. County of N/A	
Funeral Director		214-26-7904	7. Age (In yrs. last to 82		If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day 10-4-1	921	D. Birthplace (State or Foreign Country) Md
a-f chow	ctor	Usual Residence of Decedent 10a. State 10b. County Md N/A	10c. City, To	own or Loca					10d. Inside City Limits 1 XYes 2 ☐ No
th with the 23a or 28	ai Director	10e. Street and Number 4419 Belvieu Ave	nue		10f. Zip Code 21215		1	USA	
ING 21215-0035 be filed within 72 hours after death with the Maryland tial Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner mant te notified at	by Funeral	11. Marital Status 1 Never Married 2 Marned 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 ☐ No If Yes, Give Year or Dates:	lf Y	es, specify Cubai	spanic Origin? (Spe n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black,	American Indian, White, etc. Black
Baltimore, Maryland 21215-0036 bernit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural, or any joury or other traumatic event, the Madical Examinations."	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 8th grade		(Give ki life. DC	nt's Usual Occupa nd of work done of NOT use retired, fe Worke	luring most of worki)	ng	16b. Kind of Busin	
land 2	To Be Co	17. Father's Name (First, Middle, Last) Boyd Wilson				18. Mother's Name		Maiden Sumame)	
re, Marylan s 1 and 2 should be t Health and Mental Item 27 is marked other traumatic ev	-	19a. Informant's Name/Relationship (Type Barbara Feaster -	. ,			and Number or Rura			
Baltimore, IN permit, Pages 1 and 2 Department of Health Important: if Item 27 any injury or other tr		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place	of Disposit etery, crema	tion (Name of tory or other place rial Par	θ)		20c. Location - Ci Randa11	ity or Town, State
Baltil permit. F Departm Importar any inju		21. Signature of Funeral Sarvice License	K. Jones	22.		ss of Facility Mar 4300 Wab		West nue Bal	to, Md 21215
B760, cate be executed Wedica Examine but sician and the butial-transit	Examiner	23a. Part1. Enter the disease, or complic shock, or heaft failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	ce of):	RHMTH Cotic		1AS aul		Approximate Interval Between Onset and Death
Records, P.O. Box 68/60, The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3∐E	ectopic pregnancy Other (specify)			23d. Date Month	
rds, P. quires that t n signed by	þ	Part II. Other significant conditions con	tributing to death but not resultin	g in the und	derlying cause give	en in Part I.	1		oute to the cause of death? Probably 4 □Unknown
	Completed						24a. Was a autop perfor 1 Yes	sy pri med) de	ere autopsy findings available or to completion of cause of ath? Yes 2 No
ing Physician: The Mer this certificate uneral director, pag	To Be	27. Manner of Death 1 Natural 5 Pending		Outpatient b. Time of Injury	3 DOA Otho	4 Nursing Ho	me 5□ Resid	ence 6 Other	
Division o To the Hapital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification;	2 t Accident investigation 3 t Suicide 6 to Could not be 4 the Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, stree			28f. Location (S City or Tow		or Rural Route Number,
Habita 24 hours Funeral letely filled	Medical C	29a. Certifier 1 Certifying Physic (Check only one) 2 Medicel Examir	sician: To the best of my knowled ner: On the basis of examination and manner stated.	dge, death and/or inve	occurred at the tinestigation, in my of	ne, date and place, pinion, death occurr	and due to the o	cause(s) and manr date and place, an	ner as stated. Id due to the cause(s)
To the To the compl	Me	29b. Signature and title of certifler 30. Name and address of person who co	insums		29c. Licens	e number 2408	7	29d. Date signed ((Month, Day, Year)
)		30. Name and address of person who co	mpleted cause of death (Item 23	a) (Type, P	ABAS11	AVE	; BAL	T. MO.	21215
Regis	state strar	31. Date filed (Month, Day, Year)	32. Registrar's Signature	and of	•				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Anthony Wise State of Maryland / Department of Health and Mental Hygiene
04-00318

1- For State Unpend Item #23a&27 per me G828 2/10/04 tas Certificate of Death

Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last)
ANTHONY WISE 3. Time of Death WISE Year Physician January 12, 2004 0347 P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Hagerstown Washington County Hospital Washington 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 1 M 2 □ F Days Hours 29 Yrs. 212-88-3086 Director Aug. 8, 1974 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at Washington M.D. 1 ☐ Yes 2 No Director Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 5 M.D. House of Corrections 21746 U.S.A. or Items 23e by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after cand of Health and Mental Hydjene.
ant: If item 27 is marked other than "naturel; or Her
ury or other traumatic event, It as Marilical Examinat 1 Never Married 2 ☐ Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a: Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Unknown 12th Home Improvement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Shaw Rosetta Downing ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosetta Wise- Mother 3151 Lyndale Avenue Balto., M.D. 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 1/15/2004 Woodlawn, M.D. permit. Page Department of Important: If any injury or ang injury or 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Nutter Funeral Home Inc. 2501 Gwynnsfalls Pkwy Balto, M.D. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Atherosclerotic cardiovascular disease /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate the leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Tor 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 XNo 3 Probably 4 Dunknown Completed peen 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No certificate 1 🔀 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1√XYes 2 No Certification: To 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a To the Funeral D filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 O.C.M.E. January 13, 2004 Jasha NLD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

32. Régistrar's Signature

6

2004

		•	State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No.	004 00923
	Physici		1. Decedent's Name (First, Middle, Last) George WARDRICK January 5	Year 200 4 6 20 M
	/Medic Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Mercy Medical Center Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth	nty of Death A
	Funeral Director		218-62-5642 18 M 2 F 48 Yrs. Months Days Hours Min. (Month Day, Year) May 29, 1955	Birthplace (State or Foreign Country) Unk
	Maryland f show	jo	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Baltimore	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	with the	Director		of What Country?
9	72 hours after death with the Maryland natural', or items 23a or 28a-f show disal Examiner must be notified at	Funerai	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	SA lace - American Indian, llack, White, etc.
21215-0036		Completed by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	Business/Industry unk
and 21,	be filed ital Hygi id other event, I	Be	unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Suma	ame) unk
Maryland	d 2 should th and Men 7 is marke traumatic	၉	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Tow	m, State, Zip Code)
αĵ	ss 1 an of Heal item 2 rothar			21202 n - City or Town, State
Baltii	permit. Page Department of Important: If any injury or once.		21. Son re of Funeral Price Licensee de la rector State Anatomy Board 655 W. Baltin Baltimore, MD 21201	more Street
	Physician /Medical		23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as e consequence of):	Approximate Interval Between Onset and Death JEGYS
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying. Due to (or as a consequence of):	
,092	tte be executed tysician and ne burial-transit	cai Examine	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
89	death certificate e attending phys id for use as the		IF FEMALE: 23c. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy 23d. If yes, outcome of pregnancy	Date of delivery
.O. Box	0 0 0	Physician/Med		Month Day Year
ords, P	law requires that the as been signed by th 2 should be detache	δ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 230. Did tobacco use co acquired immuno deficiency Syndrome, 1 yes 2 No	ontribute to the cause of death? 3 Probably 4 Nnknown
Division of Vital Records,	The ate h page	Completed	autopsy performed? 1 Yes 2 DNo	b. Were autopsy lindings available prior to completion of cause of death? 1 Yes 2 No
r Vit	ysici is cer direc	To Be	25. Was case referred to medical examiner? 1	other (Specify)
o uo	Attending Ph ir death. ector; After th by the funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 4 Injury M 1 Yes 2 No	urred
Divis	al or Atter s after dea il Director ed in by the	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Nun City or Town, State)	nber or Rural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funaral Director; After th completely filled in by the funeral	Medical (29a. Certifiler (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and my opinion, death occurred at the time, date and place and manner stated.	
	To t Com	×	20000	ned (Month, Day, Year) Lipry 5, 200 4
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Place Baltimere A	10 21202
	Sta Registr	-	31. Date filed (Month, Day, Year) JAN 1 6 2004 32. Registrar's Signature	

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 11:40 AM **Physician** January 2004 Jean A. Williams /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Washington County Hospital Hagerstown Washington 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1□M 2♥F Feb 4, 174-22-5643 83 1920 Pennsylvania Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State Item 27 is marked other than "natural", or items 23a or 28e-1 show other traumatic event, the Wedical Examinar must be multiled at 1 Yes 2 No Washington Hagerstown Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 20009 Rosebank Way 21742 USA 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after on of Health and Mental Hygiene. Int: if item 27 is marked other than "natural", or item 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No white Specify: Baltimore, Maryland 21215-0036 Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) teacher education 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Thomas Roy Allen Aida L. Kennedy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Williams/son 26 Grove Creek Circle Smithsburg, MD 21783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
eny injury or ot
once. 1 Bunal 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 21. Signature of Euneral Service Licensee Ronald S. Wade nous Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Gause (Final disease or condition resulting in death) 5 runes a Physician 12 UV-7 /Medical Due to for as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Û Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Unknown as been signal 2 Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy page 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Cther: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DDA ္က After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1. Natural 1 Yes 2 No investigation 2 Accident Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASS IL 01111 Calerie 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1 - For State Registrar	State of M	larylan		artmen rtificate					giene Reg. No.	200	Secretary of the second	00	925
	Share in t		1. Decedent's Name (First, Middle, Las	t)							2. Date of De Month	ath Day	Υ,	ear	3. Time o	f Death
	Physici /Medic		Doris F. Zelle	er			,				Jan.	14	200		5:30	A
	Examin	er	4a. Facility Name (If not institution, give)		4b. City,	Town, or	Location of	of Death		4c.	County of I	Death		
			Charlestown Care						atons						more	
	Funeral		Social Security Number 6. Security Number	9x 7.A □M 2√2 F		last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da	th y, Year)		Coun		
	Director		215-07-8397 Usual Residence of Decedent	- X	87	115.					Aug. 22,	, 191	6	Mar	yland	
	and and		10a. State 10b. County		10c. City	y, Town or Lo	cation							1	0d. Inside C	ity Limits
	Mary	ō	MD Balt	imore		,	Arbuti	10							1 🗌 Yes	M⊃ No
	288 288	Director	10e. Street and Number	Imore			10f. Zip		-			10g. Citiz	ten of Wha	t Coun	itry?	
	3a or		5211 Shelbourne R	load				21	227			Unit	ed St	2+0		
	death with the Maryland ma 23a or 28a-f show findst be rediling at	Funeral	11. Marital Status	12. Was Decedent	t Ever in U.	S. 13.	Was Deced			gin? (Spe	ecify Yes or No Rican, etc.)		4. Race -	Americ	an Indian,	
	or Ite		1 Never Married 2 Married	Armed Forces	No		1 Tes, spec 1 □ Yes 2			i, Pueno	Hican, etc.)	ì	Black, \			
3-003e	72 hours after natural; or Ite	1 by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	:		10 105 2	ZINO	<i>Зрвспу</i> :				Specify:	Wn	ite	
'n		Completed	15. Decedent's Ed (Specify only highest gra			16a. Deced (Give	kind of wor	k done o	lurina mosi	t of worki	ng	16b. Kir	nd of Busin	ess/Ind	dustry	
717	Althin Personal Perso	d m	Elementary/Secondary (0-12)	College (1-4or	5+)	life. I	DO NOT us					USF&	G Ins	ura	nce C	0.
7	e filed within at Hygiene. other than "		12 17. Father's Name (First, Middle, Last)				Ste	enog	raphe		(First, Middle,	Maidan	Sumamal			
	ntat hed of	Be	Alfred L. Bruckso	h									Sumamer			
5	2 should be and Mental is marked raumatic sv	ပ္	19a, Informant's Name/Relationship			19h Mailin	Addross	(Street a			s Weave		Tour Sta	ta Zin	Cadal	
-	d2s than than trau		Joseph M. Zeller												0000)	
e,	1 and 1 Health tem 27		20a. Method of Disposition	Husballu	20b. P	lace of Dispo	sition (Nam	ne of	-		Arbutus Date		cation - City		wn, State	
	Pages nent of int: If it iry or o		1 🕅 Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation a 5 ☐ Other (Specify		9	emetery, cren don Par	•		. (1 10	2004	D = 1			M	
Daitim	artme ortan injur		21. Signature of Funeral Service Licen		Loud	22 /22	. Name an	d Addres	s of Facilit	1-19	-2004 ose Fun	Dal oral	timor	e,	MD DC	
ñ	permit. Pages 1 and 2 should by Department of Heath and Menta Important: If item 27 is marked any injury or other traumatic syngce.		· allerine 1) Oller	AM						Rd., A					
	31000		23a. Part1. Enter the disease, or comp	lications that cause	d the death								<u> </u>		Approxima	te
	Physician		shock, or heart failure. List only immediate Cause (Final	one cause on each	iine.	00		Tin						ļ	Interval Be Onset and	
,	/Medical		disease or condition resulting in death)	a Due to (or as	s a consequ	uence of):	new	ing					-			
Ш	Examiner		O and the first are different	h	,	1/2	beer	nes!		110	are					
	D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	s a consequ	uence of):			- 12	to have	-					
	ecuter and trans	Examiner	that initiated events	c												
Ď	oe exe		resulting in death) Last	Due to (or as	s a consequ	uence of):										
00/0	certificate be executed ding physician and ise as the burial-transit	dlcal	•	d												
0 X	w requires that the death certific been signed by the attending pl should be detached for use as t	/Me	IF FEMALE:	Ole If year outsome	/											
DOX	death c	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	death 3	Ectopic pre					2	3d. Date of Month			Year
5	the de	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	at time of de	Bath 5	Other (spe	өспу)								
	requires that the neen signed by th hould be detache		Part II. Other significant conditions of	ontributing to death I	but not resu	ulting in the ur	nderlying ca	ause give	n in Part I.		23e. Did t	obacco us	se contribu	te to th	e cause of	death?
ecords,	uires I sign Id be	d by	Slegues	e dest	n de	N					1 🗆 🕆	Yes 2	JNo 3[] Prob	ably 4 🗍	Unknown
Š	w req beer shou	Completed									24a. Was	an	24h Wer	e autor	osy findings	available
D L	The taw sate has b page 2 st	m									autop		prior	to con	npletion of c	ause of
	in: T ificati or. pa	O	25. Was case referred to medical						00 01	-15: 15	1 Yes	2/2 No	1 🗆	Yes	2□ No	
5	ysician: The law iis certificate has b director, page 2 s	o Be	examiner?	Hospital:	iont 201	ER/Outpatien		Othe			n <i>(Check only o</i> me 5 □ Resid			0	,	
5	<u>></u> .₩ 0	-	27. Manner of Death	28a. Date of Inj	ury	28b. Time of		8c. Injury Work			28d. Describe I			<i>эрөсп</i> у	")	
DIVISION	Attending Physician: r death. ector: After this certifics by the funeral director.	I	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	ay Year)	Injury	М		:? ∕es 2 🔲 ا	No						
<u> </u>	Attendion of the form of the f	iffice	3 ☐ Suicide 6 ☐ Could not be determined	286. Place of in	njury - At ho	me, farm, str	eet, factory	, office		1	28f. Location (Street and	Number o	r Rurai	Route Num	iber,
5	spital or Attending Phous after death. earal Director: After th	Certification:	4 - Homeas	building, e	itc." (Specify	()					City or Tov	vn, State)				
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: At completely filled in by the fu		29a. Certifier (Check only 2 Medical Exam	ysician: To the best	t of my know	wledge, death	occurred a	at the tim	e, date an	d place, a	and due to the	cause(s)	and manne	r as sta	ated.	
V	To the Hos within 24 h To the Fur completely	edical	one) 2 Medical Exam	iner: On the basis of and manner s	tated.										tne cause(s	5)
	To t	Σ	29b. Signature and title of certifier	aus	m		29c	License	number	101	0	29d. Date	signed (M	fonth, L	Day, Year)	/
	16		1 1. 6		/		1	100	010	VT			11	71	01	
	(1)		30. Name and address of person who o	completed cause of	death (Item	23а) (Туре,	Print)	1	hos	ce	Cans.	Ca	Tom	vil	le 1	10
	-0		31. Date filed (Month, Day, Year)	1V V Pagiet	rar's Signal	ture	- Tu		0-0		Cane,				217	28
	Sta Registr	-	JAN	1 6 2004		in di	1 De	200/2	1							

State of Maryland / Department of Health and Mental Hygiene ? 00926 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 6:00 a M January 2004 James R. Bowersox, Sr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Severna Park Anne Arundel 305 Fernwood Drive If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Aug. 21, 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1⊠M 2□F 78 Maryland 220-14-2245 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10a, State 10h County Itams 23a or 28a-f show 1 ☐ Yes 2X No MD Anne Arundel Severna Park Director 10f Zin Code 10g. Citizen of What Country? 10e. Street and Number 21146 USA 305 Fernwood Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 132 Yes 2 □ No ff Yes, Give Year or Dates: ₩W II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Never Married 2 X Married Specify: White "natursl", or 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) Colfege (1-4or 5+) Purchasing Manager Westinghouse permit. Pages 1 and 2 should be filed with Depertment of Health and Mental Hygiene Important: If Itam 27 is marked other that any jointy or other traumatic event, the 9008. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Joseph Bowersox Helen Dingle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 305 Fernwood Drive Severna Park, MD 21146 Marie Bowersox/Wife 20c. Location - City or Town, State January 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery 2004 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee & Sons, P.A. Ritchie Hwy. Severna Park Funeral H Severna Park, MD 21146 Thomas // 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) di sease arkinson Uzars **Physician** /Medical Due to (or as a consequence of) Examiner Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, physician Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ page 2 should be 3 Probably 4 Dinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ormed No 1 ☐ Yes 2 ☐ No 1□ Yes certificate Division of Vital To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitaf: 1 ☐ Inpatient 2 No 3 DOA 1 🗌 Yes 2 ER/Outpatient Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manne of Death 28b. Time of After 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No М hours after death. 2 Accident 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) þ 4 Homicide To the Funeral Director To the 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of centifier 50725 rans Huy Millersville 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) Ter Day, Year) State JAN 0 6 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth ZIS AT Month **Physician** Tanyany Wesley Clyde Baker /Medical 4b. City, Town, or Location of Death 4c. Connty of Death 4a Fecility Name (If not institution, give street and number) Examiner RUNDEL JU21016 HUNE HRUNDE OSTITIAL GLEN CRTH 8. Date of Birth (Month, Day, Year) Jan. 31,1923 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. lest birthday) Funeral Months Days Hours 11XIM 2□ F 80 Yrs. 527-14-2508 WA Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 end 2 should be filed within 72 hours after death with the Marylar Department of Health end Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any Injury or other traumatic event, it a Medical Examiner must be notified at 1 □ Yes 2∛ Š No Severna Park MD Anne Arundel **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 532 Bowline Road 21146 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11 Maritel Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give White 1 ☐ Yes 2X No Specify: Specify: Baltimore, Maryland 21215-0020 Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Detes: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Presbyterian Pastor Clergy 5+ 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Evelyn Cooney William Clyde Baker 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 532 Bowline Road, Severna Park, MD Corinne O. Baker/Wife 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Jan 6, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 2004 21. Signal of Fundral Service Listins 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Myocardial Infarction /Medical Immediate Cause (Final disease or condition resulting in death) Examiner edical Certification: To Be Completed by Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 D Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 2 No 2 PNo 1 Tyes 1 Yes 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpetient 3 DOA this 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Menger of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 T Accident 6 Could not be determined 3 □ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

or Attending Physician: The law requires that the death certificate be executed To the Hospital or Attending Physical within 24 hours after death.

To the Funerel Director: After this completely filled in by the funerel di

29c. License number 5 29d. Date signed (Month, Day, Yeer) 29b. Signature and title of certifier

Hospital Drive, Glen Burnie, MD, 21061 30. Name and eddress of person who completed cause of deeth (tem 23e) (Type, Print) SLOVGE

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

4 T Homicide

(Check only one)

29a. Certifier

31. Dete filed (Month, Day, Year) JAN 0 8 2004

32. Redistrar's Signature

State of Maryland / Department of Health and Mental Hygiene

					Ce	ertificat	e of	Death		R	eg. No.	UU4	00921
	1. Decedent's Nam	e (First, Middle, La	ist)							2. Date of Deat	th		3. Time of Death
ian cal	Elizabeth	n Mary Be	ellon							Jan.	Dey 4	2004	02:00 AM
ner	4a. Facility Name (/	f not institution, giv	re street and nur	nber)		-		b. City, Tow	n, or Lo	cation of Death	4c. Co	unty of Death	
	Homewood	at Cruml	and Far	ms				Frede	ric	k	Fre	ederic	k
	5. Social Security N	umber 6. S	Sex	7. Age (In yrs.	last birthday) If Under Months	1 Year Deys	If Under 2 Hours		8. Date of Birth (Month, Day,			place (State or Foreig
	154-10-02	223	1□M 25≹F	90	Yrs.	WIGHTIS	Deys	riours	IVIII.	06/01/1	913	000	NY
	Usual Residence of 10a. State	Decedent 10b. County		100 0	tv. Town or L	anation.							
-			•										10d. Inside City Limit
Scto	MD	Frederic	eK .	Milc	ld1eto								1 □ Yes 2 ∏ No
E Dire	10e. Street and Nur 7215 Lime		ine			10f. Zip	Code 2176	9		1	0g. Citizen USA	of What Cou	ntry?
Jer	11. Marital Status		12. Was Dece	dent Ever in U	,S. 13.	Was Deced	lent of H	ispenic Origi	in? (Spe	ecify Yes or No- Rican, etc.)	14.	Race - Ameri	
Be Completed by Funeral Director	1 ☐ Never Marri	ed 2 Married	Armed For 1 Tyes If Yes, Giv Year or Da	2 X No e		If Yes, spec 1 ☐ Yes 2		n, Mexican, Specify:	Puèrto	Rićan, etc.)		Black, White, ec <i>ify:</i> Wh:	
sted	(Spec	15. Decedent's E	ducation		16a. Dece	edent's Usue	ol Occup	ation	of work	ina	16b. Kind o	of Business/Ir	ndustry
mple	Elementary/Seco		College (1	-4or 5+)				during most of	01 440170	y			
ဒ္ဓ	12	(E)			l He	omemak	cer					ome	
Be	17. Father's Neme ()							(First, Middle, M		name)	
ို	Paul Hlav				1					th Kanic			
	Nancy E.			er						wn, MD 2		wn, Stete, Zij	o Code)
	20a. Method of Disp			,	Place of Disponentery, cre	osition (Nam	ne of	e)		Date 2	20c. Locati	on - City or To	own, State
		Tremation 3 ☐ 5 ☐ Other (Specif		state	ithsbu			•	13	/5/04	Smith	sburg	MD
	21. Signature of Fu	neral Service Licer	isee /	<u> </u>				s of Fecility					neral Home
	1/2=	20	1						Ge.	eet, Hag			
	23a. Part1. Enter th	ne disease or com	plications that or	aused the deat						, ,		JWII, I'II	Approximate Interval Between
/Medical Examiner	Sequentially list cor if any, leading to im cause. Enter Under Cause (Disease or that initiated events resulting in death) L	nditions, mediate mylying injury	a. <u>Co</u> Ro.	Due to (c	or as a conse	quence of):							V
Completed by Physician/N	Part II. Other signific	cent conditions of	dontributing to de. そらべい	ath but not res	ulting in the u	underlying ca	use give	en in Part I.			pacco use		o the cause of deeth
2	Severe	mitrae 1	المادمة	tation	,					24a. Was er	autones	24h W	ere autopsy findings
ē	polmeno	ary hy	perten	Nois						perform	ed?	av	ailable prior to
ᄐ	alaa	al-oto y	ed or its	lunga	ry dis	sease						_	death?
3	Critonia		, , , , ,	, ,	1					1 □ Ye	s 2 1110	1 [☐Yes 2☐No
g B	25. Was case referr exeminer?		Hospitel:				Oth		of Death	(Check only one)		
0	1 ☐ Yes 2 ☐ 1 27. Manner of Death		1 U Ir	-	ER/Outpatie			4 LI Nurs		ne 5 Resider		Other (Specif	y)
ation	1 DMaturel 2 Accident	5 □ Pending investigation	28e. Date o (Monti	n, Day Year)	28b. Time o Injury	M ZE	3c. Injury Work 1 □ `	rat (? /es 2∐No		8d. Describe ho	w injury oc	curred	
Medical Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	286. Place	of Injury - At ho g, etc. <i>(Specif</i>)	ome, farm, st	reet, factory,	office		2	28f. Location (Str. City or Town,	eet and Nu State)	mber or Rure	l Route Number,
edical	29a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exen	ysician: To the bandiner: On the band mann	sis of examina	wledge, deat tion end/or in	h occurred e vestigation,	t the tim	e, date and pointion, death	place, a	nd due to the ca od at the time, da	use(s) and te and plac	manner as si ce, and due to	tated. the cause(s)
Ř	29b. Signature and	title of certifier	LRO	earl	2 cery	29c.		onumber O48	8	29	d. Date sig	gned (Month,	Dey, Yeer)
	30. Name and addre	ess of person who			123a) (Type,		M	1000	TO	in in	5. 2	1769	
e ır	31. Date filed (Monti	JAN 06 2	32. R	gistrar's Signa	ture	perkir							

Phys /Me Exar

Funer Direct

Baltimore, Maryland 21215-0020

Physicia /Medica Examine

D.OD: 1/4/04

findion-to physician as: Einabeth Bellon

			1 - For Amend Item#5perFf Registrar Item#24aperVFF	State of Maryland BALG8282/18/04 E	d / Depa พ <i>Cer</i>	rtment of H tificate of L	ealth and Death	Mental Hyg	es. No. 2004	00929
			1. Decedent's Name (First, Middle, Last)					2 Date of Deat	h Day Year	3. Time of Death
	Physicia Medic		Pauline W. Bottger					Kinia		WH 0420M
	Examin	er	4a. Facility Name (If not institution, give s			4b. City, Town, or		th	4c. County of Dea	on County
			Washington County 5. Social Security Number 6. Sex		ast birthday)	Hagers If Under 1 Year	If Under 24 Hrs	8. Date of Birth (Month, Day,		tholace (State or Foreign
	uneral irector		כלנט כח פסף	M 2⊠F 94		Months Days	Hours Min	January		entucky
ъ			Usual Residence of Decedent	140.00	-					10d. Inside City Limits
arytar	show Id at	٦	10a. State 10b. County		, Town or Loc agersto					1 ∑Yes 2 □ No
We M	28s-f	Director	Maryland Washingto	JII 11k	igersu	10f. Zip Code		1	Og. Citizen of What Co	ountry?
with	lbe or		1304 Pennsylvania	Δ17 Θ		21742			U.S.A.	
death with the Marytand	тв 23	Funerai		12. Was Decedent Ever in U.	S. 13. V		spanic Origin? (Specify Yes or No-	14. Race - Ame Black, Whit	
after	or Ite		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2X No If Yes, Give		Yes 28 No	Specify:	no moan, etc.)	Specify Whi	
UUSO hours af	En	d by	3 Widowed 4 □ Divorced	Year or Dates:				1		·
72.	"nat edica	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give	ent's Usual Occupa kind of work done of OO NOT use retired	during most of wo		16b. Kind of Business	rindustry
within	than the	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)	Boo	kkeeper/S	ecretar	У	Federal G	overnment
d be filed	other smt,	Be C	17. Father's Name (First, Middle, Last)			1	18. Mother's Na	me (First, Middle, M		
uld be	rked tic av	To B	Walter Lee Willia	ms			Gertru	de May Wi	se	
2 sho	ls ma	. 1	19a. Informant's Name/Relationship (Type						, City or Town, State, . Maryland	
and land	m 27 her tr		Donna Staggers/Dau 20a. Method of Disposition			sition (Name of	nane na		20c. Location - City or	
nor	nt: If Ite		1 ☐ Burial 2 ☑ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	C	emetery, cren	atory or other place g Cremato	ry ¦ Jan			, Maryland
Dairimor	Department of result and worked other than "natural", or items 23e or 28s-f show mortant: if them 27 is marked other than "natural", or items 27 is marked other than eny injury or other traumatic avent, the Medical Examiner must be notified at 000cs.		21. Signature of Funeral Service License	98	13	Name and Addres	ss of Facility D	ougalas A N. Hager	stown, Mb.	neral Home
ا م	1 = 0 a	1	23a. Part 1. Enter the disease, or complishock, or heart failure. List only on	cations that was the death				Λ		Approximate
/M Exa	physician and ledical aminer sthe burial-transit	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	uence of):	The S	y Muc	e Cla	ed dieuse	Onset and Death
.O. BOX of	been signed by the attending phy. should be detached for use as the	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
Ords, P	ned b	by Pf	Part II. Other significant conditions con	•	ulting in the ur	iderlying cause give	en in Part I.	23e. Did tob	pacco use contribute to	1.6
COLOS,	en sig ould b	ed t	4/9/Milline	4~				1 🗆 Ye	s 2 No 3 P	obably 4 Pinknown
I MeC	ate has page 2	Completed	/					24a. Was ar autops perform 1 Yes 2	y prior to ned? death?	utopsy findings available completion of cause of
or Vital	n. After this certificate funeral director, pag	Be	25. Was case referred to medical examiner?	lospital:	Dio :	othe Othe	26	eath (Check only on		- Marie 1
P Pys	r this ral di	. To	1 ☐ Yes 2 ☐ No	28a. Date of Injury	Proutpation 28b. Time of	28c. Injun	4 Nursing	~ ,	ence 6 Other (Spe ow injury occurred	city)
DIVISION For Attending	: Afte	tior	1 ♣Natural 5 ☐ Pending investigation	(Month, Day Year)	Injury		C? Yes 2 □No			
Atter	# # F	fice	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify	me, farm, stre	eet, factory, office		28f. Location (Sti City or Town	reet and Number or Re n. State)	ural Route Number,
Jo la	d in by	Serti	4 Hornidae							
Hospital or 1	Funeret Directory (illed in by	dical Certification:	29a. Certifier 1 Certifying Phys	sician: To the best of my kno ner: On the basis of examinal and manner stated.						
Hospita 24 hours	willing 24 hours ariet dear To the Funeret Director: completely filled in by the		29a. Certifier 1 Certifying Phys	ner: On the basis of examinal			oinion, death occ	curred at the time, da		to the cause(s)
To the Hospital or within 24 hours after	To the Functs after Completely filled in by	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Exemin	ner: On the basis of examinal		estigation, in my op	oinion, death occ	curred at the time, da	ate and place, and due	to the cause(s)
To the Hospital or a within 24 hours after	To the Funerel Direct completely filled in by	edical	29a. Certifier (Check only one) 1 Certifying Physical Exemination (Check only one) 2 Medical Exemination (Check only one) 29b. Signature and title of certifier AMU/	ner: On the basis of examinal	tion and/or inv	29c. License	oinion, death occ	curred at the time, da	ate and place, and due	to the cause(s)

		A	State of Maryland / Department of Health and Mental Hygien Amend Item#SperFHG828 2/21/04 EW Certificate of Death	10930									
			1. Decedent's Name (First, Middle, Last) 2. Date of Deeth	3. Time of Death									
	Physic /Medi		IOHN LOUIF RURKE January 5 2004	9:40 PM									
	Exami		4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death										
			Genesis Elder Care La Plata Charles										
ı	Funeral Director		579-40-8377 X - 71 III. 12/23/1932 Washing	gton, DC									
	and ***		Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d.	Inside City Limits									
	Marylan f show	ō	MD Charles White Plains	1 □ Yes 2X □ No									
	the M	9	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country	?									
	72 hours after death with the Maryland natural', or flems 23s or 28s-f show fitel Examiner must be notified at	Funeral Director	9440 Billingsley Road 20695 U.S.A.	U.S.A.									
		ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Black, White, etc.										
36		by Fu	L If Yes, Give 1 L Yes 2V No Specify: 1 Specify: 1 L ≥ 1 .										
21215-0036	tural'	8	2 Stylidowed 4 Divorced Fear of Dates: 1451-54										
15	ithin 72 na. nan "na	Completed	(Specify only highest grede completed) (Give kind of work done during most of working life. DO NOT use retired)										
212	7.00	E	Elementery/Secondery (0-12) College (1-4or 5+) 12 Mail Carrier US Post Office	ce									
	al Hygi f other	Be	b 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)										
Maryland	d 2 should be filed the and Mantal Hyg 7 is merked othe trsumetic event,	2	Mary Anne Boland										
Mar	d 2 sh h and h sm T is m trsum		19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Co	de)									
	s 1 and of Haalth itam 27		Theresa A. Barnard - daughter 4305 Marion Lane, Waldorf, MD 20601 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town,	State									
Baltimore,	ages ant of it. It: If ite y or o		1 Of Burial 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) cemetery, cremetory or other piece) 1-9-2004 St. Joseph's Cath Cemetery Pomfret, MD										
Ħ	permit. Pages Department of Important: If it any injury or of	ŀ	21. Signature of Funeral Service Licensee M00053 22. Name and Address of Facility Huntt Funeral Home										
ä	9 E 2 G	bv	Mark G. Buhann P. O. Box 156, Waldorf, MD 20604										
			23e. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,	proximate erval Between									
	Physician		A. Or	nset and Death									
1	/Medical Examiner		Immediate Ceuse (Final disease or condition resulting in death) e. CauNcuef at Teref disease Due to (or as a consequence of):										
		je l	Due to (or as a consequence of):										
	uted d ansit	Examiner	b										
o,	sician and burial-transit	EX	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury C.										
68760,	cate be execui physician and the burial-tran	odical	C	es e consequence of):									
_	daath certifi e attanding id for use as												
Box		clan											
P.0.		ysi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the	e cause of death?									
	s that ned b	by Physiclan/M	Hyperlee sial	iy 4 dikilowii									
ğ	requiras that tha een signed by th hould be datache	8	Dail Company 24b. Were availal performed?	autopsy findings ble prior to									
Records,	2 55 8	Completed	complete variation of dea	etion of cause									
Œ	ysician: The l s cartificate he diractor, page		1 TYPS SEENC 1 DY	es 212 No									
/ita	Iclan: The cartificate ractor, pag	Be	25. Was case referred to medical against 26. Place of Death (Check only one)										
of Vital	Physician: this cartific ral diractor,	2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)										
LO LO	After After funer	E I	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury M 28b. Time of Injury M 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred										
Division	Attending or death. actor: After by the fune	flea											
Ö	a after if Dire	S E											
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After complately filled in by the funer	dlcal (29a. Certifier (Check only one) 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state end manner as state.										
	othe othe	¥	29b. Signeture and title of certifier 29d. Date signed (Month, De)	, Year)									
	->-0		D0056949 117104										
(30. Name/and eddress of person who completed ceuse of death (Item 23a) (Type, Print)										
1	B 10:1		Dr. Kamakshi Baig, 6620 Crain Hwy, Suite 102, La Plata, MD 20646										
	Sta Registi		31. Date filed (Month, Dey, Year) 32. Refistrer's Signeture										

DHMH 16 Rev 6/95

ORIGINAL

		1 - For State Registrar	State of Maryla	nd / Dep	artment o		d Mental Hy	giene Reg. No. 201	0093	
Physici /Medic Examin	al	Ronnie Gler Recility Name (first, Middle, Las Ronnie Gler Aa. Fecility Name (If not institution, give	nn Burke		4b. City, Tow	n, or Location of De	2. Date of De Month Jan 1,	Day Y	3. Time of Death 0157	
Funeral Director				Clint If Under 1 Y	ON ear If Under 24 h	frs. 8. Date of Bir (Month, Da	Prince	ce George's 9. Birthplace (State or Foreig Country) 1. Washington D		
I and 2 should be filed within 72 hours after death with the Maryland F and Mental Hygiene. Items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Ge 10e. Street and Number 8600 Mike Shapi 11. Marital Status 1 Never Married 2 Married 3 Widowed 15. Decedent's Ed (Specify only highest grace Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) William Henry II 19a. Informant's Name/Relationship (7) Anna Burke (Mother	ro Drive Apt 12. Was Decedent Ever in the Amed Forces? 1	J.S. 13. 16a. Dece Give life. Const	207 Nas Decedent f Yes, specify (1 Yes 2 7. Jent's Usual October North Service (2 Yes	of Hispanic Origin? No Specify: coupation and during most of withred) 18 Mother's N Anna reet and Number or	(Specify Yes or Note to Rican, etc.) working tial lame (First, Middle, a Holt Ale	United United 14. Race - Black, V Specify: 16b. Kind of Busin Self Em Maiden Sumame) exander or, City or Town, Sta	10d. Inside City Limit 1 Yes 2 N XX It Country? States American Indian, White, etc. White ess/Industry ployed	
permit. Pages 1 at Department of Hea Important: If Item eny injury or othe once.		20a. Metrod of Disposition 1	Removal from State	rt Linc	. Name and Ad	place) netery Jai Idress of FacilityLe	ee Funera	l Home,Ind	orTown, State urg, Maryland c 6633 Old cyland 20735	
te be ysicia	ical Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only commediate Cause (Final disease or condition resulting in death) Sequentially list conditions, Tany leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. MULT Due to (or as consec	(PLE quence of):		AN F			Approximate Interval Batween Onset and Death	
The law requires that the death certificat ate has been signed by the attending phy bage 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o	al death 3	Ectopic pregna Other (specify)			23d. Date of Month	detivery Day Year	
w requires that the signed by should be detacted.	ed by Ph	_						_	cco use contribute to the cause of death?	
	Completed	25 W						sy prior death 2 No 1 1 1		
문 등 교	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Dale of Injury (Month, Day Year)	28b. Time of Injury	28c. ir	Other: 4 Nursing	28d. Describe h	ence 6 Other (Sow injury occurred	Specify) Rural Route Number,	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Medical Ceri	29a. Certifier 1 Certifying Phy	building, etc. (Special sicien: To the best of my knother: On the basis of examinal and manner stated.	owledge, death	estigation, in m	y opinion, death oc	curred at the time, o	averte) and manner	due to the cause(s)	
B4	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VENCAT S. CAMBRON 7501 SUCCAT75 Corbs #13 ate 31. Date filed (Month, Jay, Year) 6 2004 32. Ref strar's Signature						07 CU	1/1 NON M	104 D 20735	

			1 - State Registrar	State of Ma	ryland / De	partme		lth and l	Mental Hyg		004	009	932	
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last) WALLACE EUGENE BARNES 4a. Facility Name (If not institution, give street and number)				, Town, or Loc	ation of Deat	2. Date of Dea Month JANUARY	Day 1,			Death M	
Funeral Director			211 32 2130		CENTER (In yrs. last birthdi 67	ay) If Unde		Under 24 Hrs. ours Min.	8. Date of Birth (Month, Day DECEMBER	Year)	9. Birthp Cour MARY	lace (State or	Foreign	
e, Maryland 2	within 72 hours after death with the Maryland ene. than "nature!, or flems 23s or 28s-! ehow its Medical Evaninar must be notifiad at	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County MARYLAND CHARLES 10e. Street and Number	3	10c. City, Town or	•	i- Codo			0.00		0d. Inside City		
	eath with Is 23a or 3		409 UNIVERSITY DR	ver in U.S. 1		ip Code 2060		10g. Citizen of What Country? UNITED STATES Specify Yes or No- 14. Race - American Indiar						
	be filed within 72 hours after death with the Marylan ital Hygiene. Ide dygiene. Ide other than "naturel", or flems 23s or 28s-f show other than "naturel", or flems 23s or 28s-f show event, the Medical Evantiner must be notified at		1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:		1 ☐ Yes	XXNo S	to Rican, etc.) Black,		ack, White,	White, etc.			
	I within 72 tiene. I than "nati		15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12TH GRADE	ucation de completed) College (1-4or 5-	(G life	ive kind of w e. DO NOT i	ual Occupation ork done during use retired) SERVICE	g most of wor		16b. Kind of I	Business/Ind ATION	dustry		
	should be filed volumental Hygie marked other I		17. Father's Name (First, Middle, Last) CHARLES HENRY BARN				18. J.	Mother's Nam	ne (First, Middle, I	Meiden Suma FORD B	me) ARNES			
	nd 2 state are trau		19a. Informant's Name/Relationship (7) MARY ADELATOE BARNES /		409	UNIVERS	TTY DRIV		RF, MARYLA	ND 2060	02			
	permit. Pages 1 ar Department of Hea Important: If Item any injury or othe once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify)	SACRED HE	ART CHU	other place) RCH CEM.		5, 2004	20c. Location				
Ba	Departiment of the post of the		21. Service Liberal Service Liberal Lypia C. THORNION J	OHNSON MOOSE	33	3439 LL	IN FUNERA VINGSION	ROAD.	NDIAN HEAD	, MARYL	AND 20	640 Approximate		
I Records, P.O. Box 68760,	The taw requires that the death certificate be executed The same state of the attending physician and the second of the attending physician and the second of the second	ted by Physician/Medical Examiner	23a. Part1. Enter the disease, or companies shock, or heart failure. List only of the shock of heart failure. List only of the shock of	Due to (or as a Due to (or as a c.	consequence of): Consequence of): Consequence of): CONSEQUENCE OF):	AN	FAILL	RE				Interval Betwo		
			nysician/Me	nysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death	3 □Ectopic p 5 □ Other (s _i					ate of delive onth	
	w requires that been signed b should be deta		Part II. Other significant contributing to death but not resulting in the underlying cause given in Part I.							23e. Did tobacco use contribute to the cause o			ath? nknown	
	Physician: this certific al director,	e Completed	25. Was case referred to medical				20	Diagram of Day	24a. Was all autops perform	ned? No	prior to con death?	psy findings av apletion of cau	railable use of	
		To Be	examiner? 1 Tes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA				Place of Death (Check only one) Nursing Home 5 Residence 6 Other (Specify))			
		ai Certification:	27. Manner of Death 1. Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	08 Olega of laive. At home form street factor (f)			2 🗆 No	28d. Describe how injury occurred						
Div	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer										20001 20 01	atad	эг, 	
	the Hos in 24 h the Fur ipletely	Medicai	one) 12 Medical Exem	iner: On the basis of e and manner state	examination and/or	investigation	n, in my opinior	n, death occur	red at the time, da	ite and place,	and due to	the cause(s)		
	Vith Vith To	2	29b. Signature and title of certifier	D		29	c. License nun D538	_	29	od. Date/signe	/			
j	BID		VIGTY TO TO	nANAN	7501 5	URRA		COAS	#307	CLIA	VWN	MD 20	0735	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar	's Signature	Sperke								

			1 - For State Registrar	State of M	aryland	/ Depa		of H	ealth and			2004	00933
Н	Physic	an	Decedent's Name (First, Middle, Last Charlotte	R R			Butler			2. Date of De Month	ath Da	y Year	3. Time of Death
	/Medi	cal								Januar		2004	1:30 A M
	Examir	ner	4a. Facility Name (If not institution, given Morningside House			root	4b. City, To Wald	-	Location of Dea	th	40 C	. County of Dear harles	th
	Funeval		5. Social Security Number 6. S		e (In yrs. las		If Under 1		If Under 24 Hrs	8. Date of Bir			thologo /State or Foreign
	Funeral Director			□м 2⁄ДF	84	Yrs.		Days	Hours Min	. (Month, Da	iy, Year,	919 Pen	thplace (State or Foreign ountry) nsylvania
	/land		10a. State 10b. County		10c. City, T	Town or Lo	cation						10d. Inside City Limits
	Many	ģ	Maryland Charles		Waldo	orf							1 TXYes 2 □ No
	J within 72 hours after death with the Maryland jiene. r then "natural", or llams 23a or 28e-f show the Medical Exandrar must be multipal at	Funeral Director	10e. Street and Number				10f. Zip C				-	tizen of What Co	ountry?
	ath w	rai	701 Village Stree	t 			206	02			US	SA	
	ar de Itams	nue	11. Marital Status	12. Was Decedent Amed Forces?		13. V	Vas Decede Yes, specif	nt of His y Cuban	panic Origin? (8 , Mexican, Puer	Specify Yes or No to Rican, etc.)	-	14. Race - Ame Black, White	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 XI If Yes, Give Year or Dates:	No	1	☐ Yes 2	ON D	Specify:			Specify: Bl	ack
Ş	2 hou	per	15. Decedent's Ed	ucation	1	16a. Deced	ent's Usual	Occupa	ion		16b K	ind of Business/	Industry
215	within 73 ene. then "na he Medi	pie	(Specify only highest gra	de completed) College (1-4or 5	=	(Give life. L	kind of work OO NOT use	done du retired)	iring most of wo	rking	Orr	ind of Business/ hans Co	ürt'of
2	filed wit Hygiene ther the	Completed	12	Conege (1-40)	(Offic	e Mana	iger			Pe	ennsylva	IIId
Maryland 21215-0036	& g al B	To Be (17. Father's Name (First, Middle, Last) Bruce	I	Ransom				18. Mother's Na Bessie	me (First, Middle,	Maider	Sumame) Hamilto	n
ary	" = m =	-	19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailin	g Address (S	Street ar	d Number or R	ural Route Numbe	er, City o	or Town, State, Z	Zip Code)
	and 2 salth a n 27 is		Bruce C. Ransom/N	ephew					een Ter	race Lan	dove	r,Maryl	and 20785
Baltimore,	es 1 au of Hea fitem rothe		20a. Method of Disposition 1 □ Burial 2 🛣 Cremation 3 □	Domoval from State	ceme	etery, cren	sition (Name	er place		Date	20g L	cation - City or exandria	Town, State
<u>Ĕ</u>	Pages ment of I ant: If its ury or o		'4 □Donation 5 □Other (Specify		Metro	opoli	tan Cr	ema	tory 1	/5/04		irginia	•
ä	permit. Pages Department of Important: If it eny injury or o		21. Signature of Funeral Service Licen		1417 7		Name and	Address	of Facility				
_	₫ Ω 등 5 0		Odesoa O		101323					e P.A. A		co, Mary	land
	Anysician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or composition shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	one cause on each li	ESTIV a consequen	E ice of):			FAILU 10 PATH		1651,		Approximate Interval Between Onset and Death
8760,	cate be executed physician and the burial-transit	ai Exa	resulting in death) Last	Due to (or as	a consequen	ce of):							
387	physicate physical ph	edicai		d									
.O. Box 6	The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□ Unknown	2 Fetal de	ath 3□	Ectopic preg Other (spec					23d. Date of deli Month	very Day Year
٠.	that the the the the the the the the the th		Part II. Other significant conditions co	ontributing to death b	ut not resultin	g in the un	derlying cau:	se given	in Part I.	23e. Did to	bacco u	se contribute to	the cause of death?
Records,	quires n sigr ald be	d by						-		1 □ Y	es 2	□No 3□Pro	bably 4 Onknown
8	law requir as been si 2 should l	Completed								24a. Was a	30	24b. Were aut	opsy findings available
8	icien: The lav certificate has rector, page 2	E								autop	med?	prior to o	ompletion of cause of
酉	en: rtifica tor, p	BeC	25. Was case referred to medical						26. Place of Dea	1 ☐ Yes ath (Check only or	2 20 No	1 🗆 Yes	2 No
2	nysici nis ce direc	To E	examiner? 1 □ Yes 254 No	Hospital: 1 ☐ Inpatie	nt 2□ER/	Outpatient	3□ DOA			lome 5 Resid		6 □Other (Spec	ify)
Division of Vital	Attending Physicien: r death. ector: After this certific: by the funeral director,	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	y 28t Year)	b. Time of Injury	28c	. Injury a Work?	t s 2 □ No	28d. escribe h			,
VIS	Atter	ifica	3 Suicide 6 Could not be	28e. Place of Inju	ury - At home,	, farm, stre	et, factory, o	ffice		28f. Location (S	treet an	d Number or Rur	ral Route Number,
	s after al Dire	Sert	4 - Horricae	building, etc	:. (Зреспу)					City or Tow	n, State,)	
	To the Hospital or Attending Physicien: The within 24 Hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical (29a. Certifier (Check only one) 1 Certifying Physical Exam	rsician: To the best of iner: On the basis of and manner sta	examination	dge, death and/or invi	occurred at lessing at the stigation, in	the time my opir	date and place ion, death occu	, and due to the c rred at the time, d	ause(s) late and	and manner as a place, and due to	stated. to the cause(s)
;	To the within To the comple	Me	29b. Signature and tille of certifier				29c. L	icense r	number	2	9d. Dat	e signed (Month,	Day, Year)
,			> Valle me					1)(8885			1/3/200	04
			30. Name and address of person who co	ompleted cause of de	eath (Item 23	a) (Type, P	rint)					12/	1
D	BID		VENKAT. S. KAMAM		1 Sul	rrat-	15 K	099	# 303	t Clin-	Ton	ms	20935
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 7	2004 32. Halistra	r's Signature	y. 19	mi)					

	m,end Item#15,16a,bpe 1- State Amend Item Registrar		rh G82	28 2/2	Cert	ificate of	Death	7		Reg	. No.	_			
1	Decedent's Name (First, Middle, L	HALEY	MAR	IE CO	DLLI	NS			2. Date of Month		Day 2 0 0 4	Year 1		3. Time of 921	Death M
	4a. Facility Name (If not institution, g					4b. City, Town, WESTM						ty of De			
		Sex 1□M 2ÅF		yrs. last bir	thday) Yrs.	If Under 1 Year Months Days		r 24 Hrs. Min. 1 4	8. Date of (Monte) 1 / 2	1 Birth 1, Day, Y	ear)		irthplace Country)		Foreign
	Usual Residence of Decedent 10a. State 10b. County PA YO	B.K.	100	c. City, Town		ation							10d.	Inside Cit	
200	10e. Street and Number 125 SCOTT ST.				VIII	10f. Zip Code 173	31			10g	. Citizen d	of What C			
completed by runeral billector	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Dec Armed Fo 1 ☐ Yes If Yes, Gi Year or D	orces? 2.[X]No ve	in U.S.	lf '	as Decedent of Yes, specify Cub	an, Mexica	n, Puerto	ecify Yes o Rican, etc	or No- .)	В	ece - Am lack, Wh	ite, etc.		
ווישופופת	15. Decedent's (Specify only highest g		1-4or 5+)	-	(Give ki	int's Usual Occu ind of work done O NOT use retire	during mo	st of work	ing	16	b. Kind of	Busines	s/Indust	try	
o pe co	17. Father's Name (First, Middle, Later CLAYTON I		COLLI		NONE			-	e (First, M			a <i>m</i> e)			
0	19a. Informant's Name/Relationship		`ATHE			Address (Stree					ity or Tow			de)	
	00 11:15:1-15:5						,								
	20a. Method of Disposition 1 Burial 2 XCremation 3 4 Donation 5 Other (Spec	□Removal from	State AL	Ob. Place of cemeter L COU	Disposi	tion (Name of			Date	20	c. Location	•			
100	20a. Method of Disposition 1 □ Burial 2 ⊠Cremation 3 4 □ Donation 5 □ Other (Special Service Lice) 21. Signature of Funeral Service Lice 22. Signature of Funeral Service Lice 23. Signature of Funeral Service Lice		State A L	ob. Place of cemeter L CO	Disposiny, crema UNT	tion (Name of	ATIO	1 1/	Date 7/04 ETCH	SY ER F	c. Location KES' UNE	VILI RAL	E,	MD.	57
	1 ☐ Burial 2 ☑Cremation 3 1 ☐ Donation 5 ☐ Other (Spec	ensee mplications that only one cause on e	State AL caused the each line.	L COI	Disposing, crema UNT \ 22. 2 5 4	tion (Name of atory or other play Y CREMA Name and Addres 4 E. MA	ATIOI ess of Faci	J 1/	Date 7/04 ETCH WES	SY ER F IMIN	c. Location YKES' YUNE: ISTE!	VILI RAL	HOI	MD.	een
	1 Burial 2 XCremation 3 4 Donation 5 Other (Special Control of Special	mplications that c by one cause on e Due to	State A L	L COU	Dispositive, crema UNT) 22.	tion (Name of atory or other plate) Y CREMA Name and Addres 4 F. MA	ATIOI ess of Faci	J 1/	Date 7/04 ETCH WES	SY ER F IMIN	c. Location YKES' YUNE: ISTE!	VILI RAL	HOI	MD. ME 211 proximate erval Betv	een
icai cxamner	1 Burial 2 X Cremation 3 4 Donation 5 Other (Special Service) Lice 21. Signature of Funeral Service Lice 23a. Part 1. Enter the disease or coshock, or flear failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	mplications that only one cause on e	State A L aused the each line. (or as a continue as a co	cemeter L COI	Dispositive, crema UNT) 22. 1 25.4 not enter	tion (Name of atory or other plate) Y CREMA Name and Addres 4 F. MA	ATIOI ess of Faci	1 1/	Date 7/04 ETCH WES	SY ER F IMIN	c. Location YKES' YUNE: ISTE!	VILI RAL	HOI	MD. ME 211 proximate erval Betv	een
	1 Burial 2 XCremation 3 4 Donation 5 Other (Special Control of Special	mplications that of the property of the cause on each of the cause of	State AL caused the sach line. (or as a continue of property of property continue of proper	death. Do not be a sequence of the sequence of	Disposiny, crema UNT) 22. 25 4 not enter of):	tion (Name of atory or other plate) Y CREMA Name and Addres 4 F. MA	ATION Sass of Facility Sang, such a	1 1/	Date 7/04 ETCH WES	SY ER F IMIN	c. Location YKES' YKES' YNE YNE NSTE	VILI RAL	HOMAD.	MD. ME 211 pproximate erval Betvalset and C	een
r II yalcıdı izinedicai Ez	1 Burial 2 XCremation 3 4 Donation 5 Other (Special Control of Special	Due to a. Due to b. Due to c. Due to d. Pregr	State AL Caused the sach line. (or as a cold come of prointh 2 nant at time own	death. Do not be a sequence of the sequence of	Disposity, cremate UNTY 22. 125 4 not enter of):	tion (Name of atory or other platery or other platery or other platery or other platery or other platery or other platery or other platery or other (Specify)	ATION Sess of Facility Session and Session	N 1/lity FL:	Date 7 / 0 4 ETCH: WES' or respirate	SY SY ER F PMIN ony arrest	c. Location YKES' YKES' YNE YNE NSTE	Pate of de Aonth	HOI Applications of the series	MD. ME 211 proximate erval Betval set and C	een eath
r II yalcıdı izinedicai Ez	1 Burial 2 XCremation 3 4 Donation 5 Other (Special Control of Special	Due to a. Due to b. Due to c. Due to d. Pregr	State AL Caused the sach line. (or as a cold come of prointh 2 nant at time own	death. Do not be a sequence of the sequence of	Disposity, cremate UNTY 22. 125 4 not enter of):	tion (Name of atory or other platery or other platery or other platery or other platery or other platery or other platery or other platery or other (Specify)	ATION Sess of Facility Session and Session	N 1/lity FL:	Pate 7 / 0 4 ETCH WES' Or respirate 23e.	SY ER F FMIN Ory arrest Did tobac	23d. Coo use co	VILI RAL R, N Date of de Month	HON Application of the calculati	MD. ME 211 proximate erval Betval set and C	een eath
be completed by ringsicial/medical Ex	1 Burial 2 XCremation 3 4 Donation 5 Other (Special Control of Special	b. Due to b. Due to c. Due to d	State AL caused the sach line. (or as a continue of proper to the sach line of proper to the sach line own leath but no	death. Do not be a sequence of the sequence of	Disposing, crema UNT) 22. 1 25 4 not enter of):	tion (Name of atory or other platery or other platery or other platery or other platery or other platery or other platery or other or other (specify)	ace) ATIOI ass of Facilia AIN S ang, such a	N 1/lity FL: ST., s cardiac	Date 7 / 0 4 ETCH WES' or respirate 23e.	SY ER F FMIN Ony arrest Did tobac I Yes Was an autopsy performer es 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	23d. L	Date of de Aonth Ontribute Ontribute	HOMAN Application of the calcula	MD. ME 211 proximate erval Between And E	een eath
edical cerumoanon. To be completed by rugsicial/medical channing	1 Burial 2 XCremation 3 4 Donation 5 Other (Special Control of Special	Due to b. 23c. If yes, out 1 Live to 4 Pregr 9 Unknown a contributing to do Hospital: 1 28a. Date (Mon	State AL caused the sach line. (or as a continue of property of the property of the property of the property of the property of Injury Year	death. Do not need to be consequence of the consequ	Disposity, crema UNTY 22. 25.4 of): of): 3 of): stipatient Time of njury	tion (Name of atory or other platery or other platery or other platery or other platery or other platery or other platery or other platery or other or other (specify)	ace) ATION Sess of Facility AIN Sending, such a	N 1/ lity FL: ST., s cardiac	Date 7 / 0 4 FTCH. WES' Or respirate 23e.	SY ER F PMIN Ory arrest Old tobac I Yes Was an autopsy enformed as 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	23d. Course cour	Date of de Aonth Date of de Aonth Do Were a prior to death? 1	HON Application on the care of	MD. ME 211 proximate erval Between and D ause of de 4 U findings a ation of ca	ath? ath? athereas

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit. To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

Physici /Medic Exami

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exam. act must be cotified at once.

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

Muchael R, Barull

D34916

1/3/04

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200 MEMORIAL DR., WESTMINSTER, MD. 21157 CARROLL

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For 1/6/04 BEM
State AACO. Health Dept. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Mary Carter 2004 <u>3:1</u>0 a ^M January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 602 McKinsey Park Drive Unit 306 Severna Park Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🖾 F 82 383-12-1541 Yrs. Nov.5, Director 1921 Michigan Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show the Medical Examinar must be notified at Anne Arundel MD Severna Park 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 602 McKinsey Park Drive Unit 306 21146 USA by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Registered Nurse Medical other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be . Pages 1 and 2 should ba fii ment of Health and Mental H tent: If item 27 is marked ott jury or othar treumetic even Mathew J. Breitenbeck Mary A. Quinlan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21146 Edward G. Carter/Husband 602 McKinsey Park Drive Unit 306 Severna Park, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition January 7, 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If eny injury or once. MD Veterans Cemetery 2004 `4 ☐Donation 5 ☐ Other (Specify) Crownsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. 495 Gov. Rithcie Hwy. Severna Park Funeral H Severna Park, MD 21146 nonna 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death u **Physician** MONOY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Entar Uniterlying Cause (Disease or injury that initiated accounts.) Due to (or as a consequence of): Examiner physician and s the burial-transit or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Division of Vital Records, 2 No 3 Probably 4 ☐ unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To Aftar thi funeral of 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Diractor: , completely filled in by the f 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 028401 MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peterson 600 Rid Chert 31. Date filed (Month, Day, Year) JAN 0 6 2004 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygienes Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 02,2004 **Physician** MARGARET THERESA CRAMER JANUARY 10:13A^M /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) NOV.16,1928 9. Birthplace (State or Foreign Country) NEW JERSEY **Funeral** 1 □ M 2 □ F Director 138 22 1322 75 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10h County ?7 is marked other than "natural", or items 23a or 28a-f ahow traumatic event, the Medical Evantimer must be notified at 10d. Inside City Limits Director 1 Yes 2 No MARYLAND ANNE ARUNDEL ANNAPOLIS 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 930 BAY FOREST COURT 21403 UNITED STATES Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after I Department of Health and Mental Hygiene. I important: If item 27 is marked other than "naturel", or ther any injury or other traumatic event, the Medical Franch Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER HOME 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) JOHN THOMAS COSTELLO MARY BOYLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT L. CRAMER (HUSBAND) 930 BAY FOREST COURT ANNAPOLIS.MD. 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 ACremation 3 Removal from State KALAS CREMATORY 01-03-04 * 4 ☐ Donation 5 ☐ Other (Specify) EDGEWATER, MD. 21. Signature of Euleral Swice Licenses 22. Name and Address of Facility GEORGE P. KALAS FUNERAL HOME 2973 SOLOMONS ISLAND_ROAD EDGEWATER.MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) Myocardial **Physician** Interction hours /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month 4□Pregnant at time of death Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Artery Difease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 **⊠**Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed?

1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Certification; To 1 Npatient 2 ER/Outpatient 3 DOA this After thi funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of offifier 29c. License number 29d. Date signed (Month, Day, Year) D46052 112/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) annapolos Bech, Vanhway serd 2001 Medical 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 5 2004 Registrar

			1 - State of Mar Registrar		artment of Health and tificate of Death	Mental Hygier	_ 4004 00001
	Physici	an.	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	3. Time of Death
	/Medic		Leo Edward Clem			January	2 2004 5.06
8	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Deal	h *	4c. County of Death
V	F		Washington County Hospital 5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	Hagerstown If Under 1 Year If Under 24 Hrs	8. Date of Birth	Washington 9. Birthplace (State or Foreign
	Funeral Director		214-09-9469 ^{1⊠M 2□F}	83 Yrs.	Months Days Hours Min		ar) Country)
	Q .		Usual Residence of Decedent			TOCCODEL I	
	arylar show	_		10c. City, Town or Lo			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	8a-f	ecto	Maryland Washington	Hagersto		10	**
	with t	Funeral Director	10e. Street and Number		10f. Zip Code 21740		Citizen of What Country? USA
	eath	erai	622 Salem Avenue 11. Marital Status 12. Was Decedent Ev	ver in U.S. 13. V			14. Race - American Indian,
10	r Hen	Fun	Armed Forces? 1 ☐ Never Married 2 ☐ Marned 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		Was Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	Black, White, etc.
ဗ္ဂ	ral', o	ğ	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1	1 ☐ Yes 2 💢 No Specify:		Specify: White
21215-0036	within 72 hours after death with the Maryland ene. then 'natural', or items 23a or 28a-f show Ita Medical Exactina maal be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupation kind of work done during most of wo	rking 16b.	Kind of Business/Industry
12	hen hen	шb	Elementary/Secondary (0-12) Cotlege (1-4or 5+		DO NOT use retired)		1 771 4
2	illed v Hygie other t	ပိ	12 1 17. Father's Name (First, Middle, Last)	Snee	tmetal Mechanic	me (First, Middle, Maid	oyd Kline
an	ould be Mental I warked o	To Be	Joseph Clem			e Boyce Cle	
Maryland	should ind Men inarke	-	19a. Informant's Name/Relationship (Type, Print) Daugh	tor 19b. Mailin	ng Address (Street and Number or R	<u> </u>	
	and 2 eath a n 27 to		Michael Joyce Poffenberger		alem Avenue, Hag	erstown, Ma	1. 21740
Zre,	of He of He item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispo- cemetery, cren	sition (Name of natory or other place)	Date 20c.	Location - City or Town, State
Ĕ	Pages ment of I ant: If its ury or o		`4 ☐Donation 5 ☐ Other (Specify)	Rest Have	en Cemetery 1/6/	2004 Ha	gerstown, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Medical Examine trausal be notified at ODGe.		21. Signature 1 Funeral Service Licence	22	. Name and Address of Facility Re	st Haven F	uneral Chapel
	<u> </u>		23a. Part1. Enter the disease, or complications that caused the		501 Pennsylvania		gerstown, Md. 21742
ĝi.	Iciate be executed /Medical Examiner superioristical and superioristical forms of the forms of t	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	consequence of):	Ecronary Vas	cular Dis	Interval Between Onset and Death
8760,	ysiciar y buri	calE	d.				
P.O. Box 68	Attending Physician: The law requires that the death certificate be executed rideath. rideath. ector: Atter this certificate has been signed by the attending physician and be the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tire 9 □ Unknown	Fetal death 3	Ectopic pregnancy		23d. Date of delivery Month Day Year
J.	s that med t	by PI	Part II. Other significant conditions contributing to death but	not resulting in the ur	nderlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
ğ	w require been sig should b		Fracture Right Fee	nu_		1 🗆 Yes	2 No 3 Probably 4 Unknown
Division of Vital Records,	Physician: The law rethis certificate has be al director, page 2 sh	Completed	Chronic rent faile	lik .		24a. Was an autopsy performed 1 Yes 2 📮	
Ĭ	certifi	Be	25. Was case referred to medical examiner? Hospital: Hospital:			ath (Check only one)	
o	Phys	: To	27. Manner of Death 28a. Date of Injury	2 ER/Outpatien 28b. Time of	t 3 DOA Survey at Work?	dome 5 Residence	6 ☐Other (Specify) jury occurred ©24 pol 24,
O	nding Ph th. : After th s funeral	tlor	1 □ Natural 5 □ Pending (Month, Day 1 2 ☑ Accident investigation	Year) Injury		Fell Whee	
N S		iffice	a Co : 1 6 Could not be	y - At home, farm, stre (Specify)			and Number or Rural Route Number,
ō	tal or	Certification;	lto u			622 Sale	A. Ayestuant
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	edical	29a. Certifier (Check only 1 ☐ Certifying Physician: To the best of 2 ☑ Medicel Exeminer: On the basis of e	xamination and/or inv	n occurred at the time, date and place vestigation, in my opinion, death occ	e, and due to the cause urred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
	To the h within 24 To the f complete	Med	onel and manner state	art			
	7 × 0		Silver Line Dille	2	Da 10/2	70-	2 2014
. 11	34		30. Name and address of person who completed cause of de-	oth (Item 23a) (Tune	Print) 19 011 -02-	400 d +	100000 120
5	4-		Edward W. Ditto W.	2	14010 C force	n. 140	21742
- 100	Sta	ite	29b. Signature and title of certifier Show with without 30. Name and address of person who completed cause of dea Edward w. Ditto to F 31. Date filed (Month, gay Year) 5 2004 32. Registrar	's Signature	1 and		43
	Registr	ar	U U CUUT	in H. W	parel		

Baltimore, Maryland 21215-0036

Box 68760.

Division of Vital Records.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- State UNPEND ITEM 23a&25tate of Maryland 28 Repartment of Health and Mental Hygiene 2 DORETHA DYSON 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2004 Year Physician JAN. 4, Doretha Perkins Dyson 0616 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ST.MARY'S ST.MARY"S HOSPITAL LEONARDTOWN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🖾 F 48 Director 577-74-4745 13, 1955Washington, DC Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show al', or items 23a or 28a-f shov Examiner must be notified at St. Mary's 1 ☐ Yes 21 No Maryland Great Mills Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 45965 Fox Chase Apt.# 10 USA death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ੴ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 1 Married 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced **Black** "natural" er than "natur. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mental Hygiene. 10th Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Menta tem 27 is marked Perkins Daniel ဥ Mary Virginia Lawrence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Herbert James Dyson 45965 Fox Chase Apt.# 10, Great Mills, MD 20634 (Husband) Hem 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State tment of 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Important: I any injury o once. ` 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols 1-12-2004 Charlotte Hall, MD 21. Signal of Funeral Reprice Linensee Edward N. Brinstield, permit. 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Jr. M00052 Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician PNEUMONIA** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ending physician and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy fo Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1

X Yes 2 □ No 24a. Was an certificate ha autopsy performed? 1XYes 2□No Hospitel or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) · 1XYes 2 No Certification: To 2XXER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1XXNatural 5 Pending within 24 hours after death.

To the Funerel Director: A completely filled in by the fu М 1 TYes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E JAN. 5, 2004 taligula 30. Name and address of person who completed Ause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year) JAN 1 3

32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

			1 - For State Registrar		Marylan	d / Depa		t of H	ealth and Moeath	-		20	04	00939
	Physic /Medi Exami	cal	1. Decedent's Name (First, Middle Wilbur Leo Doy 4a. Fecility Name (If not institution Anne Arundel M	e , give street and numb	_{er)} ter		,	Town, or	Location of Death	2. Date of D Month	Day 3, 4c.	2004 County o	of Death	3. Time of Death 8:52 AM
-	Funeral Director		5. Social Security Number 236-62-5048 Usuel Residence of Decedent		Age (In yrs.) 64	ast birthday) Yrs.	If Under Months	-	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D June 12	rth	39 I		ace (State or Foreign V) Virginia
	the Maryland 28a-f show	rector	10a. State 10b. County	Arun d el	1	nnapol		Code			10g Citi	izen of Wh		d. Inside City Limits 1 ☐ Yes 2 No
9	72 hours after death with the Maryland "natural", or Itama 23a or 28a-f show idical Examinar must be notified at	Funeral Director	508 Harbor Dri 11. Marital Status 1 Never Married 2 Marr	12. Was Decede Armed Force	s?		214 Was Deced f Yes, spec	03 lent of History Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)	Unit	ed St	tates - Americai , White, et	n Indian,
21215-0036	⊆ 2	Completed by	3 Widowed 4 Divorced 15. Decedent (Specify only highes Elementary/Secondary (0-12)	If Yes, Give Year or Date 's Education it grade completed) College (1-4)		16a. Deced	lent's Usua kind of wor DO NOT us	I Occupa	Specify: tion uring most of work	ing	16b. Ki	Specify: ind of Busi	whit iness/Indu	
Maryland 21	be filed ntal Hygi od other	To Be Con	12 17. Father's Name (First, Middle, John Luther Do	Last)		1	manag	er	18. Mother's Name		, Maiden	YO CE Y Sumame)	ry st	ore
	1 and 2 sho Health and tem 27 is m		Joan Dove/wife 20a. Method of Disposition	nip (Type, Print)	20b. PI	508] ace of Dispos	Harbo sition (Nam	r Dr	ive Anna	al Route Numb	MD 2			
Baltimore,	permit. Pages Department of Important: If it any injury or o		1 Burial 2 Cremation 4 Donation 5 Other (S) 21. Signature of Funeral Service	pecify)	Fort	22	oln Co . Name and	eme to	ery Jan.	n M. T.	ayloı	r Fun	eral	Home. Inc
8760,	Physician /Medical Examiner bhysician and physician and examiner is the burial-transit	dicai Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediete Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Metha Due to (or b. Reu Due to (or c. Ade	as a conseque	Po not enter Rusist ence of): Pence of):	nuts	del i	e Glouces such as cardiac haum mis-s Left	S Pm	rrest,		A Ir	G week
P.O. Box 6	that the death certifica hed by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal at time of de	death 3 🗌	Ectopic pre Other (spe				2	23d. Date of Month		
Records, P	law requires that as been signed b 2 should be det	þ		melliti	_	ting in the un	derlying ca	use giver	in Part I.	23e. Did t		,		cause of death?
Vital Rec	The ate h page	Be Completed	tryputen END Stage 25 Was case referred to medi examiner?	e tidne	ng d	ison	se.		26. Place of Death	1 Yes	rmed?	prio dea	re autopsy or to comp ath? Yes 2	y findings available letion of cause of
Division of V	or Attending Phys Iter death. Director: After this in by the funeral di	Certification; To I	27. Manner of Death 1 Neural 5 Pending 2 Accident investig 3 Suicide 6 Could n 4 Homicide	ation of be 28e. Place of I	ijury 2 Day Year)	PVOutpatient 28b. Time of Injury	28 M	c. Injury a Work?	4 Nursing Horat		dence 6 now injury			loute Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical C	29a. Certifier (Check only one) 2 Medicel E	Physicien: To the be- xeminer: On the basis and manner	or examination	ledge, death on and/or inve	estigation,	t the time in my opin	nion, death occurre	ed at the time, o	date and p	and manne place, and signed (A	due to the	e cause(s)
	> F 0		Huyl C	no completed cause of	death (Item 2	23a) (Type, P			8314		11	31	005	4
4	Sta Registr		31. Date filed (Month, Day, Year)		trar's Signatu		and de	25 1	lidgely	MUC-	HNN	vapa	451	1041E GM

DHMH 17 Rev 1/2001

ORIGINAL

	,	For State Registrar		aryland / I		nt of Health te of Deat	h	ental Hygien	~ U U L	. 000110
Physicia /Medica	al .	1. Decedent's Name (First, Middle, Last) JAMES HINES	DRYDEN	N	11.5	Tour		JANUARY C	Yeer	
Examine		4a. Fecility Name (If not institution, give s PENI HSULA PEGIONAL	MEDICA		m	- 1200	or Death SOUM or 24 Hrs. E	B. Date of Birth	County of Dee	nico
Funeral Director		5. Social Security Number 220-34-9808 Usuel Residence of Decedent	M 2□ F 7. Age	88	Yrs. Month			(Month, Day, Year 1/5/1915	9. 6	rthplace (State or Foreign ountry) MD
Maryland f show	ō	10a. State 10b. County MD Worceste	r	10c. City, Tow	m or Location					10d. Inside City Limits 1 ☐ Yes ※ No
death with the Maryland me 23e or 28e-f show Emust be notified at	i Director	10e. Street and Number 8022 Queponco				Zip Code 21841		10g. C	itizen of What C	ountry?
urs after	by Funeral	<u> </u>	12. Was Decedent E Armed Forces? 1 Yes 2X N If Yes, Give Year or Dates:	Ever in U.S. lo		cedent of Hispanic (pecify Cuban, Mexic 2 No Specifi		ify Yes or No- ican, etc.)	14. Race - Am Black, Whi Specify: W	
tiled within 72 hours at Hygiene. Ither than "natural", or int, tre Medical Exer-	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5		Decedent's Us (Give kind of life. DO NOT	sual Occupation work done during m use retired)	ost of working	16b. I	Kind of Business	
be til d otl	To Be C	17. Father's Name (First, Middle, Last) Charlton A. Dry	/den				her's Name (Della (First, Middle, Maide Givens	n Sumame)	
C = 14 F		19a. Informant's Name/Relationship (Ty) George Dryde		198				Rou <i>te Number, City</i> ewark, M		
T S T S T S T S T S T S T S T S T S T S		20a. Method of Disposition 1 M Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	cemete	of Disposition (Nory, crematory of es Ceme	r other place)	Da		ocation - City of	
permit. Page Department of Importent: If any injury or once.		21. Signature of Furnaral Service License			22. Name	and Address of Fac	The I	Burbage I Snow Hil	Funeral	
Physician		23a. Part1. En r th disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulling in death)	ations that caused e o use on each lin	TIC	not enter the m					Approximate Interval Between Onset and Death Shows
/Medical Examiner			PNEU	a consequence	۱A					1 DAY
por con, create be executed physician and sthe burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause East Underlying Cause (Disease or injury that initiated events resulting in death) Last		a consequence						
death certit e attending ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	n 3 □Ectopic 5 □ Other				23d. Date of de Month	l blivery Day Year
	Ď	Part II. Other significant conditions con DIARSETES	-	_	in the underlyin	g cause given in Pai	rt I.			o the cause of death?
The ate h	Completed	RENAL FAIL	URE					24a. Was an autopsy performed?	death?	utopsy findings available completion of cause of
Physician: The This certificate ral director, page	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	lospital: 1 Inpatie	nt 2 ER/O	utpatient 3			(Check only one) e 5 Residence	6 □Other (Spe	ecify)
Attending Pr r death. actor: Atter th by the funeral	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of Injur (Month, Da)	y Year)	Time of Injury M	28c. Injury at Work? 1 \(\text{Yes} \) 2	_No	3d. Describe how inju	ury occurred	
pitel or Attandir urs after death. arel Director: A		4 Homicide determined	28e. Place of Injubulding, etc.	c. (Specify)				3f. Location (Street a City or Town, Sta	te)	
To the Hospitel within 24 hours a To the Funerel Completely filled	ledical	(Check only 2 Medical Exami	ner: On the basis of and manner sta	f examination a ated.	nd/or investigati	on, in my opinion, d	eath occurred		nd place, and du	e to the cause(s)
with To	Σ	29b. Signature and title of certifier 30. Name and address of person who come and address of person who come and address of person who come are also address of person are also address of person and address of person are also address of person are also address of person and address of person are also address of person are also address of person are also address of person and address of person are also address of person are also address of person and address of person are also address of person are also address of person and address of person are also address of person are also address of person are also address of person and address of person are also address of person are also address of person and address of person are also address of person are also address of person are also address of person are also address of person are also address of person are also address of person are also address of person are also address of person are also address of person are also address of person are a	o	S-,	40	29c. License numbe	69	62 JA	ate signed (Mon	oz, 2006
!.H. 14	Ì	30. Name and address of person who co	ompleted cause of d	eath (Item 23a)	(Type, Print)	EGIONA	L ME	DICAL	LE NTEI	R. MD2180
Stat		31. Date filed (Month, Day, Year)	32. Kegistra	ar's Signature	Snach	5				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 00941 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2004 **Physician** J A N RAYMOND E. DEMARR 4, 3:10P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner CIVISTA MEDICAL CENTER LAPLATA CHARLES If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Reb 26 1929 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 → M 2 □ F Director 218-24-7125 74 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Directo Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11977 Montgomery Lane 20602 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 XYes 2 No If Yes, Give 1950-55 Year or Dates: 1 ☐ Yes 2 XNo Specify: Specify: White 3 ™Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Truck Driver Delivery 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Irene E. Burch DeMarr Claude L. DeMarr 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward C. DeMarr (son) 11000 Homestead Drive White Plains, MD 20695 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State Trinity Memorial Gardens 1-7-04 Waldorf, MD 4 □Donation 5 Other (Specify) 22. Name and Address of Facility Eberwein Funeral Services Funeral S 21. Signati M00173 4433 White Pls. La. White Pls., MD 20695 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only one) Hospital: 1 XInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation filled in by the f 2 Accident 3 🗌 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel I Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Dey, Year) D-21031 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

Michael

31. Date filed (Month, Day, Year) JAN 0

A Leatherwood

MD

32. Registrar's Signature

12070 Old Line Ctr Ste 202 Waldorf, MD 20602

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2, 2004 eer January DeHahn Leonard 10:30 A M /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death **Examiner** 4b. City. Town, or Location of Death 6800 Semmes Court La Plata Charles 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, NOV 27, **Funeral** 9. Birthplace (State or Foreign Hours 1**X**□M 2□F Days 1945 217-42-8501 58 Washington DC Director Usual Residence of Decedent the Maryland 10a State 10b. County rai', or items 23a or 28a-f show Examinar must be notified at 10c, City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Charles La Plata 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 6800 Semmes Court 20646 'natural', or items 23a United States Pages 1 and 2 should be filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1XX es 2 \sum No 1964-11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 Yes, Give Year or Dates: 1 ☐ Yes 2X No Completed by Specify 3 ☐ Widowed 4 ☐ Divorced 1967 White event, the Mudicul 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) then at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Heat & Air Condition. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H litem 27 is marked oth r other treumatic even Be Kenneth Howard Frances Ollerenshaw 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia C. DeHahn - Wife 6800 Semmes Court, La Plata, MD 20646 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Januarry 10 10 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or on a. 4 ☐ Donation 5 ☐ Other (Specify) 07, 2004 Waldorf, Maryland Huntt Crematory 21. Signature of Funeral Service Licenses M00053 22. Name and Address of Facility HUNTT FUNERAL HOME Prohaum 1. P.O.BOX 156, WALDORF, MARYLAND 20604 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Months Immediate Cause (Final disease or condition resulting in death) Physician Recurrent Lymphoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (classes or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burish-transit completely filled in by the funeral director, page 2 should be detached for use as the burish-transit Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Chronic Obstructive Lung Disease Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 2X) No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D12906 January 2, 2004 30. Name and address of person who co cause of death (Item 23a) (Type, Print) Kaufman, MD, Louis V. 12070 Old Line Centre, #207, Waldorf, MD 20602-2567 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 5 2004 Elem & Sperks Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registrar Certificate of Death Reg. No 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav 10:00 P M **Physician** 105,2004 ROBERT LOUIS ELBIN /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Boonsbor Keedylursingtone Washington 170 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1X M 2□ F 7. Age (In yrs. last-birthday) **Funeral** 220-10-1483 Yrs. MÁRYLAND Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State Examiner must be notified at 1 ☐ Yes 2X No Director BOONSBORO MARYLAND WASHINGTON 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21713 U.S.A. 8507 MAPLEVILLE ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (X) Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married WWII 1 ☐ Yes 2 X No Specify: Specify: þ 3 ☐Widowed 4 ☐ Divorced WHITE "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "ne any injury or other traumatic event, If a Medical page. Elementary/Secondary (0-12) College (1-4or 5+) MACHINIST GOVERNMENT ENGINEER. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be AMY HARTSOCK SILAS ELBIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18823 Burnside Bridge Road, Sharpsburg, MD SUSAN SIRICO, DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State SMITHSBURG CREMATORY 1/6/ 2003 SMITHSBURG, MARYLAND • 4 □ Donation 5 Other (2000(fy) 22. Name and Address of Facility 21. Signature of F al Service Licensee 7606 OLD NATIONAL PIKE Paul M. Dean | BAST FUNERAL HOME BOONSBORO, MAKYLAND 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PULMONARY DIS HIKONIC **Physician** 20 Y /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examine iding physicien and ise as the burial-transit Due to (or as a consequence of): Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 2Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 21 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide TCCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Hospitel of within 24 hours all To the Funerel D

OWISFIBIR

Baltimore, Maryland

721

State Registrar (Check only one)

29b. Signature and title of certifier

KHALID M. WASEEM, M.D., 1126 OP

29c. License number 052323 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1126 OPAL COURT, HAGERSTOWN, MARYLAND

State of Maryland / Department of Health and Mental Hygiene

				Certificate of	Death	Reg. No.	104 00941
	Physic	ion	1. Decedent's Name (First, Middle, Last)		2. Date Mon	of Death h Day	3. Time of Death
	Physici /Medi		Edna Mae Elgin		Janu	ary 1, 2	004 7:25a.m.
	Examir		4a. Facility Name (If not institution, give street end number)		4b. City, Town, or Location of	Death 4c. Count	y of Death
		. e	Waldorf Healthcare Center		Waldorf	Cha	rles
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Months Days	If Under 24 Hrs. 8. Date (Mon	of Birth	9. Birthplace (State or Foreign Country) 13 Maryland
	Director		217-36-5215	s. Bayo	Augu	st'30,19	13 Maryland
	pu 👱		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town				
	aryla shov	-	Maryland Charles Indian				10d. Inside City Limits
	8a-f	5		пеац			1 ☐ Yes 2 X No
	2 should be filed within 72 hours after death with the Maryland end Mental Hygiene. Is marked other then "netural", or items 23e or 28e-f show aumatic event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number	10f. Zip Code		10g. Citizen of	
	ath w	ra	6370 Chapmans Landing Road	2064		U.S.	Α.
	tems	n e	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces?	 Was Decedent of h If Yes, specify Cub 	lispanic Origin? (Specify Yes an, Mexican, Puerto Rican, et	or No- 14. Rad	ce - American Indian, ack, White, etc.
2	or i	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 24 ☐ No	1 ☐ Yes 2 ☐XNo			%:White
0200-61212	ural'	Q P	3X Widowed 4 □ Divorced Year or Dates:			5,500	/·WIII CC
γ	"net	Completed	15. Decedent's Education (Specify only highest grade completed) (6	ecedent's Usual Occup Give kind of work done	eation during most of working d)	16b. Kind of B	Business/Industry
N	he he	E	Elementary/Secondary (0-12) College (1-4or 5+)		·	17 5	Government
Z	lled v lygie her t		12 2 Mat 17. Father's Name (First, Middle, Last)	chematici			
yland	be f half half half be of	Be			18. Mother's Name (First, M		•
Š	i Mer Marke	T ₀	Charles Wallace Millar		Edna	Simmo	
<u> </u>	is n is n raun	10 0			and Number or Rural Route I		
บ์	l and leaitl m 27 her 1				ck Rd., Bry		
5	t of t		20a. Method of Disposition 20b. Place of □ cemetery,	crematory or other plac	∞Jan. 5,200	20c. Location	- City or Town, State
апптог	men ant: jury		4□Donation 5□Other (Specify) Christ	Episcop	al Church	Irons	ides, Marylan
D D	permit. Pages 1 and 2 should be Department of Health end Ments Important: If Item 27 is marked any Injury or other traumatic evonce.		21. Signature of Funeral Service Licensee	22. Name and Addre		m c D 7	20640
_	20 E # 9		M00668		Funeral Honthorne Rd.,		
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	t enter the mode of dyir	ng, such as cardiac or respirat	ory arrest,	Approximate Interval Between
	Physician		shock, other railure. List only one cause on each line.				Interval Between Onset and Death
	/Medical		Immediate Cause (Final disease or condition resulting in death) A THERO-Sc	1 EDOTIO	LICART	DECEA	+5=
	Examiner		resulting in death) a. Due to (or as a col		T) Ella /	price.	ا کار ا
		ner	545 15 (6) 45 4 54	iocquerioc oi).			
	cuted	E	5equentially list conditions.	sequence of			
'n	exectan an arriel-ti	EX	if any, leading to immediate cause. Enter Underlying				
00/00,	te be ysicia ne bu	cal	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death Last Due to (or as a conditional cond	sequence of):			
8	ertificate be executed ling physician and e as the buriel-transit	Medical Examiner	resulting in death) Last	1004001100 017.			
5	andin use	\$	d				
٥.	death d for	Physician	Part II. Other significent conditions contributing to death but not resulting in the	ae underlying cause giv	en in Part I 22h	Did tabasas uso se	ntribute to the cause of deeth?
;	ache	hys		io underlying dauge giv		1 □ Yes 2 No	
, L	s that	by P	DEMENTIA			I Tes 200 No	3 ☐ Probably 4 ☐ Unknown
3	uires n sig	5 0	HYPERTENSTON		24a.	Was an autopsy	24b. Were autopsy findings
Š	v req	ete				performed?	available prior to completion of cause
ב	e fav	Completed	CEROBRO -VASCULAR	ACCIDA	ENT		of death?
5	n: T			ALCC + D		1 ☐ Yes 2 No	1 ☐ Yes 2 ☐ No
5	sicier certif recto	Be	25. Was case referred to medical examiner? Hospital: Hospital:	otiont 3 DOA Oth	26. Place of Death (Check of		
5	Phys this raldi	2	1 ☐ Yes 2 🕅 No	Ment 3L DOA	4 Nursing Home 5		
5	fing After fune	ig	1 Natural 5 ☐ Pending (Month, Day Year) Inju	ry Worl	Yes 2 □ No	ribe how injury occurr	ed
	death death tor:	ical	2 Accident investigation 3 Suicide 6 Could not be 300 Black of Indian Athems form			(0)	
-	or Al	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	City o	on (Street and Numb r Town, State)	er or Rurel Route Number,
ָנ	urs e		20-0-0				
:	Hosp 24 ho Fune stely f	edical	29a. Certifier (Check only one) 2□ Medical Exeminer: On the basis of examination and/o and manner stated	eath occurred at the tim r investigation, in my op	ne, date and place, and due to pinion, death occurred at the t	the cause(s) and ma me, date and place, a	nner as stated. and due to the cause(s)
	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours elect death. To the Funeral Director: Alberthis certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit	ĕ ĕ	one) and manner stated. 29b. Signature and title of certifier .	29c. License	number	29d Date signer	d (Month, Day, Year)
-	F ₹ 5 8		V. Anwangarte				
-	_				20067	01-0	02-2004
R	RIH	\	30. Name and address of person who completed cause of death (Item 23a) (Ty	1 -4	CHARLOT	TEHAL	-L, MD 20622
1	NU		VIDYASAGAR ANMANGAT	マルトπ			20622
	Sta Registra	te ar	31. Date filed (Month, Day, Year) JAN 0 6 2004 32. Registrar's Signature	have.			
Jin.	r r		James 15.	Marie			
/ITM	IH 16 Rev 6/95	,		11 77 47			

DHMH 16 Rev 6/95

Projection Moderate Name (New Years Last) Charles Eric Pitt 1/8/04. CEID DE Controlled of Death Decomposition (New Years Death Decomposition (New Years Death Decomposition) (New Years Death Decomposition) (New Years Death Decomposition) (New Years Death Decomposition) (New Years Death Decomposition) (New Years Death Decomposition) (New Years Decompositi				1 - State Registrer AMEND #26 DEE			0		of Health a				2004	00	945
CHARLES EDMIN ELLIS Such Service from restors, op as sense are cannoted. Southern Maryland Hospital Center Southern Maryland Hospital Sout						4 CCID	ов сс.				2. Date of Dea	ath		3. Time of	Death
Southern Maryland Hospital Center Fundal Southern Maryland Hospital Center Southern Maryland Hospital Center Characteristics of the second				CHARLES EDWIN	ELLIS					j	L			3:38	Ам
Social Social				4a. Facility Name (If not institution, giv	e street and numb			4b. City, To	own, or Location of	of Death		4c. (County of Deeth		
ST7-54-4449 Pink February Company Comp			п					1		0411					
Usual Reactions of December 10c. Charly 10c. Chy, Town or Location 10c. December 10c. Chy Town or Location 10c. December 10c. Chy Town or Location 10c. Ch											(Month, Day	r, Year)	Cou	ntry)	
Charles W. Ellis Size Informatis Name-Reasonship (Type. Print) 19th Mailing Address (Size and Number or Plazal Rouse Names: City or Town. State, 2p Code) 17101 Milltown Landing Rd Brandywine, MD 20613 20th Mail Committee (Size and Siz					-						SEPI S	1941	Wasi	rigton	i, DC
Charles W. Ellis Size Informatis Name-Reasonship (Type. Print) 19th Mailing Address (Size and Number or Plazal Rouse Names: City or Town. State, 2p Code) 17101 Milltown Landing Rd Brandywine, MD 20613 20th Mail Committee (Size and Siz		nylan show	_	10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							•
Charles W. Ellis Size Informatis Name-Reasonship (Type. Print) 19th Mailing Address (Size and Number or Plazal Rouse Names: City or Town. State, 2p Code) 17101 Milltown Landing Rd Brandywine, MD 20613 20th Mail Committee (Size and Siz		8a-f s	ecto		George's	Bra	ndywin	e							2 X No
Charles W. Ellis Size Informatis Name-Reasonship (Type. Print) 19th Mailing Address (Size and Number or Plazal Rouse Names: City or Town. State, 2p Code) 17101 Milltown Landing Rd Brandywine, MD 20613 20th Mail Committee (Size and Siz		with ti			nding Bos	, a						•		ntry?	
Charles W. Ellis Size Informatis Name-Reasonship (Type. Print) 19th Mailing Address (Size and Number or Plazal Rouse Names: City or Town. State, 2p Code) 17101 Milltown Landing Rd Brandywine, MD 20613 20th Mail Committee (Size and Siz		leath	eral				S. 13 1			nin? (Sne	acify Yes or No-			can Indian	
Charles W. Ellis Size Informatis Name-Reasonship (Type. Print) 19th Mailing Address (Size and Number or Plazal Rouse Names: City or Town. State, 2p Code) 17101 Milltown Landing Rd Brandywine, MD 20613 20th Mail Committee (Size and Siz	0	or Iten	Fun		Armed Force	s?	i			, Puerto	Rican, etc.)		Black, White,	etc.	
Charles W. Ellis Size Informatis Name-Reasonship (Type. Print) 19th Mailing Address (Size and Number or Plazal Rouse Names: City or Town. State, 2p Code) 17101 Milltown Landing Rd Brandywine, MD 20613 20th Mail Committee (Size and Siz	3	ral', c	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date	s:		1∐ Yes 2K					Specify: WN1	te	
Charles W. Ellis Size Informatis Name-Reasonship (Type. Print) 19th Mailing Address (Size and Number or Plazal Rouse Names: City or Town. State, 2p Code) 17101 Milltown Landing Rd Brandywine, MD 20613 20th Mail Committee (Size and Siz	5	natu	etec				(Give	kind of work	done during most	t of worki	ing	16b. Kin	d of Business/in	dustry	
Charles W. Ellis Size Informatis Name-Reasonship (Type. Print) 19th Mailing Address (Size and Number or Plazal Rouse Names: City or Town. State, 2p Code) 17101 Milltown Landing Rd Brandywine, MD 20613 20th Mail Committee (Size and Siz	Ä	withir 806. than	duc		College (1-4	or 5+)			,			Cons	tructio	n	
## 433 White Pis. La. White Pis. y, MD 20695 23a Pif. Eries the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate infance death of the piscode, or heart failure. List only one cause on each line. Approximate infance death of the piscode of the pis	2	Hygi other)		Cabii	net Ma		r's Name	(First, Middle,				
## 433 White Pis. La. White Pis. y, MD 20695 23a Pif. Eries the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate infance death of the piscode, or heart failure. List only one cause on each line. Approximate infance death of the piscode of the pis	0	fental fental rked tic ev	o B	Charles W. Ellis					Edit	h I.	Fenne1	E11	is		
## 433 White Pis. La. White Pis. y, MD 20695 23a Pif. Eries the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate infance death of the piscode, or heart failure. List only one cause on each line. Approximate infance death of the piscode of the pis		2 sho	-	1.1											
## 433 White Pis. La. White Pis. y, MD 20695 23a Pif. Eries the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate infance death of the piscode, or heart failure. List only one cause on each line. Approximate infance death of the piscode of the pis	Z .	and sealth m 27			wife)	1									1
## 433 White Pis. La. White Pis. y, MD 20695 23a Pif. Eries the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate infance death of the piscode, or heart failure. List only one cause on each line. Approximate infance death of the piscode of the pis	2	it of H		1 □ ByAal 2 XCremation 3 □	Removal from Sta	ite C	emetery, cren	natory or other	er place)						
## 433 White Pis. La. White Pis. y, MD 20695 23a Pif. Eries the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate infance death of the piscode, or heart failure. List only one cause on each line. Approximate infance death of the piscode of the pis		it. Pa		7											
Physician Physician (Modician Examinor) Physician (Modician E	0	Depa Impo sny i		21. Signature of Parletan Strice Lice	MO	00173 —	111	and whi	+o D1c	y Ebe	erwein F	uner	al Serv	ices	
Physician //Medical Examiner Part Physician //Medical Examiner Physician Physicia		100		23a. Part1. Enter the disease, or com	plications that cau	sed the death	n. Do not ent	er the mode	of dying, such as	cardiac o	r respiratory arr	est,	MD 200	Approximate	9
Due to (or as a consequence of): Due to (or as a consequence of):	F	Physician		Immediate Cause (Final			1100 ~	er h.	va tou		a	1			
The part of the pa					Due to (or	as a consequ	uence of):	(1))	1617019	•	01.8867	4			
The part of the pa	6	Exammer	_	Sequentially list conditions.	b	\subset	020	62	02	l	wna		;		
The standard events are stated. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of to or penancy A December of the past of the p		nsit	nine	cause. Enter Underlying Cause (Disease or injury	Due to (or	an a ponsequ	ieuce ot):				2				
FEMALE: 23b. Was decodent pregnant in the past 12 months?		execu n and ial-tra	Exar	that initiated events	C. Due to (or	as a consequ	uence of):								
FFEMALE: 230. If yes, outcome of pregnancy 1 1 1 1 1 1 1 1 1	Ś	ysicie	cal		d										
B34 VAT BASIRMOHMAD TO KOLTA M.D. Q135 PIS rataway Rd. #210	5	ntifica ng ph	Med	IE EEMALE:								1			
B34 VAT BASIRMOHMAD TO KOLTA M.D. Q135 PIS rataway Rd. #210		ath ce ttendi	lan/I	23b. Was decedent pregnant	1 Live birth	2 🗌 Fetal	death 3					23		,	'nas
B34 VAT BASIRMOHMAD TO KOLTA M.D. Q135 PIS rataway Rd. #210	5	the a	/sic	1 ☐ Yes 2 ☐ No			eath 5	Other (spec	rty)				MORITI	Day 1	ear
B34 VAT BASIRMOHMAD TO KOLTA M.D. Q135 PIS rataway Rd. #210	-	that the ed by detact	٥		ontributing to deat	n but not resu	ulting in the un	nderlying caus	se given in Part I.		23e. Did tol	oacco use	e contribute to th	ne cause of de	eath?
B34 VAT BASIRMOHMAD TO KOLTA M.D. Q135 PIS rataway Rd. #210	3	uires n sign lid be							•		1 🗆 Ye	s 2 🗆	No 3 ☐ Prob	ably 4 ∑ U	nknown
B34 VAT BASIRMOHMAD TO KOLTA M.D. Q135 PIS rataway Rd. #210	5	s bee	olete			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	•				24a. Was a	n	24b. Were auto	psv findings a	vailable
B34 VAT BASIRMOHMAD TO KOLTA M.D. Q135 PIS rataway Rd. #210		The la	mo								perforr	y ned?	prior to cor death?	mpletion of ca	use of
B34 VAT BASIRMOHMAD TO KOLTA M.D. Q135 PIS rataway Rd. #210		artifica ctor. p	0						26. Place	of Death			1 🗆 1 65	2L NO	
B34 VAT BASIRMOHMAD TO KOLTA M.D. Q135 PIS rataway Rd. #210	5	hysic this ce at dire	0	1 ☐ Yes 2 🔀 No	¹ ∐ Inpa	-			4 □ Nur	rsing Hon	ne oM Reside	nce 6[Other (Specif)	1)	
B34 VAT BASIRMOHMAD TO KOLTA M.D. Q135 PIS rataway Rd. #210		ling P	27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work? 28d. Describe how injury occurred												
B34 VAT BASIRMOHMAD TO KOLTA M.D. Q135 PIS rataway Rd. #210	2	death death ctor: y the	ficat	2 Accident investigation M 1 Tes 2 No 3 Suicide 6 Could not be 28e Place of Injury - At home farm street factory office. 28f Location (Street and Number or Bural Route Atlant)								201			
B34 VAT BASIRMOHMAD TO KOLTA M.D. Q135 PIS rataway Rd. #210		al or / s after il Dire	Serti	4 Homicide	building,	etc. (Specify)	,, , o			City or Town	, State)	70111001 01 71010	THOUSE HUMB	ror,
B34 VAT BASIRMOHMAD TO KOLTA M.D. Q135 PIS rataway Rd. #210	:	ospita hours unera ly fille	-	29a. Certifier 1 Certifying Ph	ysician: To the be	st of my know	wledge, death	occurred at	the time, date and	place, a	nd due to the ca	iuse(s) ar	nd manner as st	ated.	
B34 VAT BASIRMOHMAD TO KOLTA M.D. Q135 PIS rataway Rd. #210	:	the H in 24 the Fi iplete		01.0)	and manner	stated.	ion and/or inv			h occurre	ed at the time, di	ate and p	lace, and due to	the cause(s)	
B34 A BASIRMOHMAD F. KOLIA M.D. CLINTON, MD 20735	ı	To To	2	29b. Signature and titte of certifier		•				~					
B3VIA BASIRMOHMAD TO KOLTA MOD. CLINTON, MD 20735 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature				Strong			00:1	U D	0803	2	2 :	01	10110	4	
State 31. Date filed (Month, Day, Year) 2. 2011/32. Registrar's Signature	YF	334h	10	BASIR MOHN	completed cause of	death (Item	23a) (Type, F	A Ma	D. 915	35	17500	y tak	VAY R	9. # 5	110
		Sta	te	31. Date filed (Month, Day, Year)	2004 ³² . Regi	rar's Signat	ure L	1		14 76	o.iv, s	1) 6	~6/33		

			Please	Obeta of Mandard (C)	
			For State	State of Maryland / Department of Health and Mental I	Tygiene 2006 0006
_	, de		Registrar	Certificate of Death	Reg. No.
	Physici /Medic		1. Decedent's Name (First, Middle, Las	Fletcher Sr. Month	Day Year 5:15 AM
4	Examin	er	4a. Facility Name (If not institution, give	street and number) 4b. City, Town, or Location of Death	4c. County of Death
Ī	Funeral Director		5. Social Security Number 6. Second Security Number 6. Second Security Number 11	7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Month, Months Days Hours Min. (Month,	Birth Jay, Year) 9. Birthplace (State or Foreign Country)
	P .		Usual Residence of Decedent		
	e Marylar Ba-f show	Director	10a. State 10b. County Md Worce	10c. City, Town or Location Polomoka	10d. Inside City Limits 1 1 1 Yes 2 □ No
	ath with the 230 or 2	rai Dire	10e. Street and Number	Apt, 2/85/	10g. Citizen of What Country?
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. It marked other than "natural", or Itams 23e or 28e-f show other traumatic evant, the Medical Examiner must be multified at	Completed by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: 1 □ Yes 2 □ No Specify:	No- 14. Race - American Indian, Black, White, etc. Specify:
2-00	72 hou 'natural	eted	15. Decedent's Ed (Specify only highest gra		16b. Kind of Business/Industry
21215-0036	2 should be filed within and Mental Hygiene. is marked other than 'saumatic evant, the Me	ompi	Elementary/Secondary (0-12)	College (1-4or 5+) Iffe. BO NOT use retired)	Construction
	be filed tal Hygid d other evant, I	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Mio	dle, Maiden Sumame)
Z	ould be Mental varked o	2	Gardner +	letcher Hattie L) runnowd
Maryland	d 2 sh th and th and traum		19a. Informant's Name/Relationship (7	ype, Print) 19b. Mailing Address (Street and Number or Rural Route Nu	mber, City or Town, State, Zip Code)
re,	es 1 and of Health fitam 27 r other tra		20a. Method of Disposition	20b. Place of Disposition (Name of Date	20c. Location - City or Town, State
Baltimore,	Page nent c ant: If		1 ⊠ Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specify	Mt. Singi Cenetary 1-9-04	Poconeko nd.
Bal	permit. Pag Department Important: any Injury c once.		21. Signature of Funeral Service	22. Name and Address of Facility BCNN is Snith Fungral P. O. BON 33 / Pace	Home and 2(4)
			23a. Part1. Enter the disease, or composhock, or heart failure. List only	flications that caused the death. Do not enter the mode of dying, such as cardiac or respirator one cause on each line.	Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	. Squammaes Cell (aremoma Lep	If Lung 6 mos
	Examiner			Oue to (or as a consequence of):	
	led nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):	
o,	e be executed sician and e burial-transit		that initiated events resulting in death) Last	CDue to (or as a consequence of):	
68760,	cate be physici the bu	dicai		d	
P.O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown	23d. Date of delivery Month Day Year
	uires that th signed by Id be detac	d by Pr	Part II. Other significent conditions co	A' D D. D.	id tobacco use contribute to the cause of death? ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
Division of Vital Records,	law require as been si 2 should b	Completed by	Chronie O.B.	structive Pulmorary Disease 24a. W.	/as an 24b. Were autopsy findings available prior to completion of cause of
a R	i: The cate h ; page		anemia		erformed? death?
Z:	siciar certif rector	Be	25. Was case referred to medical examiner?	26. Place of Death (Check on Hospital: 1 Death (Check on Other: 4 Million Home, 5 Death (Check on Other)	
ot	g Physicar this seral di	n: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	12 inpatient 22 21 voulpatient 32 00A 42 Austrig Home 32 A	esidence 6 Other (Specify) be how injury occurred
sior	tendin leath. tor: Afi the fur	catio	1 Natural 5 □ Pending 2 □ Accident investigation 3 □ Suicide 6 □ Could not be	M 1 Tes 2 No	
Divi	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:	4 Homicide determined	building, etc. (Specify)	n (Street and Number or Rural Route Number, Town, State)
	e Hosp 24 hou a Fune letely fil	Medicai	29a. Certifier 1 Certifying Phy (Check only 2 Medicel Exemone)	rslcian: To the best of my knowledge, death occurred at the time, date and place, and due to tiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time and manner stated.	he cause(s) and manner as stated. ne, date and place, and due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
•			Tregoen h	4. Bellow Ma D 29505	01-01-2004
0	H. 4		.30. Name and address of person who of GREGORIO M. BEL	completed cause of death (Item 23a) (Type, Print) LLOSO_M.D.; 53D2 CHINABERRY DR., SALISE	3112 MD 21901
7	Sta	te	31. Date filed (Month, Day, Year)	32. Projector's Signature	MAZILIV ZIBUI
	Registr	ar	JAN U 0 Z	Melia O Gordi	

Box 68760 Division of Vital Records, P.O. Aftert hours efter death. within 24 hours efter death To the Funerel Director: A completely filled in by the f To the Hospital or

State Registrar

31. Date filed (Month, Day, Year) JAN 0 6 2004

laucalis

29b. Signature and title of certifier

6620

5 Pending

investigation

CRAIN

6 ☐ Could not be determined

27. Manner of Death

1 Natural

2 Accident

4 Homicide

(Check only

3 Suicide

29a. Certifier

Certification:

and address of person who completed cause of death (Item 23a) (Type, Print) KARAKSHIBAIC HWY , STE-102 strar's Signature

28a. Date of Injury (Month, Day Year)

K. 1)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury et Work?

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

DOO 56949

LA PLATA . KD

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Dey, Year)

			For Stata Registrar	State of	Maryland / Dep	partment of Fertificate of			giene 004	00948
	Physici		1. Decedent's Name (First, Middle, La	st)				2. Date of Dea	Pay 2004	3. Time of Death 2220 M
	/Medic	al	Frances Hoover 4a. Fecility Name (If not institution, giv	n street and numb	ner)	4h City Town	or Location of Deat	January	4c. County of Death	2220 ""
	Examin	er	9804 Sharpsburg		Jei /	-	own, MD		Washingt	on
	Funeral		5. Social Security Number 6. S		. Age (In yrs. last birthda) If Under 1 Year	If Under 24 Hrs	8. Date of Birt		plece (State or Foreign
	Director		186-28-6219	1□M 2 ∑ F	67 _{Yrs.}	Months Days	Hours Min	Februar	y 12, Wayne	sboro, PA
	put		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				I Od. Inside City Limits
	Aaryla r sho	5								1 ☐ Yes 2 No
	28a-1	Director	MARYLAND Washing	ton	Hagerst	OWO 10f. Zip Code			10g. Citizen of What Cou	ntry?
	3a or	<u> </u>	9804 Sharpsburg P	ike		2174	.0		USA	
	death	Funerai	11. Marital Status	12. Was Deced Armed Ford	ent Ever in U.S. 13	l. Was Decedent of h	Hispanic Origin? (S	Specify Yes or No-	14. Race - Ameri Black, White,	
9	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or Items 23s or 28s-f show sumatic event, Ite Marical Edural terminatic event, Ite Marical Edural termination		1 ☐ Never Married 2 ☐ Married	1 Tes 2	! <u>M</u> No	1 ☐ Yes 2 ☑ No		10 (11041), 5(6.)	Specify: Whi	
5-0036	ural".	Completed by	3 ☑ Widowed 4 ☐ Divorced	Year or Dat		edent's Usual Occur	notion		16b. Kind of Business/In	
15-	n 72 n nat	lete	15. Decedent's E (Specify only highest gra	ade completed)	(Gi	re kind of work done DO NOT use retire	during most of wa d)	rking	166. Killa di Busillessyii	oustry
2121	lene.	E	Elementary/Secondary (0-12)	College (1-4		service	manager		Cafeteria	
פַ	e filec al Hyg othe vant,	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Na		Maiden Sumame)	
/lai	Menta Menta arked	10	Maurice L. Goss	ert				lda M. H		
Maryland		1	19a. Informant's Name/Relationship (• • • • • • • • • • • • • • • • • • • •	1				r, City or Town, State, Zip	Code)
	l and lealth im 27 her ti		Karen S. Deckar	d Daugh		Box 385, position (Name of	wright	Date MO	20c. Location - City or To	own State
ŏ	Pages 1 nent of H int: If Ite		1 □ Burial 2 □ Cremation 3 🛚		tate cemetery, c	ematory or other pla				Juli, Olalo
Baltimore,	it. Partmer artmer ortent njury		* 4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lice	1111	Quincy C				Quincy, PA	II Too
Ba	permit. Departr Importe any inju		> Quanta M	Morre	0	O S. Broa	d St. Wa	ynesboro	rsox Funera , PA 17268	
14	Physician /Medical	2 1	23a. Part (Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on eac	20LON		ng, such as cardia		rest,	Approximate Interval Between Onset and Death
н	Examiner			Due to (o	r as a consequence of):					
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (o	r as a consequence of):					
	outed id ansit	Examine	cause. Enter Underlying Cause (Disease or injury) that initiated events	С.						
oʻ	cate be executed bhysician and the burial-transit	EX	resulting in death) Last	Due to (o	r as a consequence of):				I	
8760,	ate be hysici	dicai		d						
9	certific nding p	/Mec	IF FEMALE:	23c If was outer	ome of pregnancy				22d Date of dollar	
Вох	death c e attend ed for us	ian	23b. Was decedent pregnant in the past 12 months?	1☐Live bir	th 2 Fetal death	B □Ectopic pregnanc	ey .		23d. Date of deliv Month	Day Year
o.	the de y the iched	ysic	1 ☐ Yes 2 🗹 No 9 ☐ Unknown	9□ Unknov						
<u>α</u>	requires that the death certific een signed by the attending p nould be detached for use as	Completed by Physician/Med	Part II. Other significant conditions	contributing to dea	ath but not resulting in the	underlying cause gr	ven in Part I.	23e. Did to	obacco use contribute to t	he cause of death?
Ö	× 0 to	ete						24a. Was	an 24b. Were auto	psy findings available mpletion of cause of
Re	The faw ite has b	m d						autop	prior to condeath?	
ta	an: T tificat tor, pë	a l	25. Was case referred to medical				26. Place of De	1 ☐ Yes ath (Check only o		2010
Ξ	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ In	patient 2 ER/Outpat	ent 3 DOA	her: 4 🗆 Nursing I	Home 5 Hesio	dence 6 Other (Specia	'y)
0 4	E e	ü.	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of (Month	Injury 28b. Time , Day Year) Injury	Wo		28d. Describe h	now injury occurred	
sio	Attending r death. actor: After by the fune	catio	2 Accident investigation 3 Suicide 6 Could not to			1.130]Yes 2□No	006 1 10		18 4 4
Division of Vital Records,	or Ati	Certification:	4 Homicide determined	200. Place	of Injury - At home, farm, g, etc. (Specify)	street, factory, office		City or Tow	Street and Number or Run vn, State)	M Houle Number,
	To the Hospitel or Attendit within 24 hours after death. To the Funeral Diractor: A completely filled in by the fu		29a. Certifier 1 Certifying P	hysician: To the b	pest of my knowledge, de	ath occurred at the ti	ime, date and plac	e, and due to the	cause(s) and manner as s date and place, and due t	tated.
	the H in 24 the F	Aedical	one)	and manne	er stated.	29c. Licen			29d. Date signed (Month,	
	To To	Σ	29b. Signature and title of dertifier	W.X	h	29C. Licen	-2/フU			2004
7	X		- Insul	W70 /		の (Print) 1111	SMEDIC	4101	MPHE PO	~~~/
i	X		MATT BE	completed cause	of death (Item 23a) (Typ	HA	RERS-	TOWN!	MAD =	21742
٨	Sta	ate	31. Date filed (Month, Day, Year)	32#Re	gistrar's Signature	/ .	1			
	Regist		JAN 0 5 20	104 /20	un D. Sy	exter				

			1 - For State Registrar	State	of Mary	/land / [Depa Cer	artment rtificate	of H	ealth a	and M	lental Hy	giene Nog. No.	2001	. 00	949
Ų.			1. Decedent's Name (First, Middle	, Last)								2. Date of Dea			3. Time o	of Death
	Physici /Medio		George	H				Но.	11y			January	Day 5,	2004	1:03	РМ
	Examir		4a. Fecility Name (If not institution,					4b. City, T	own, or	Location o	f Death			County of Dea		
			Charlotte Hall V							te Ha				. Mary	s	
	Funeral			6. Sex X M 2 □ F		n yrs. last bir 18	-	If Under 1	Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day	Year)	9. Bir Co	thplace (State ountry)	or Foreign
	Director		219–16–0884 Usuel Residence of Decedent		/	0	Yrs.					July 8,	1925		yland	
	/land		10a. State 10b. County		10	c. City, Town	n or Lo	cation							10d. Inside C	ity Limits
	Man B-f et	to	Maryland St. Mar	cys		Charlo	otte	e Hall							1 X Yes	2 □ No
	th the	irec	10e. Street and Number					10f. Zip (Code			1	0g. Citiz	en of What Co	ountry?	
	th wi	ai	37019 New Market	: Road				206	522				US	Α		
	er des	Funeral Director	11. Marital Status	12. Was De Armed I	orces?		13. \	Was Decede f Yes, speci	nt of His	spanic Orig	in? (Spe , Puerto	ecify Yes or No- Rican, etc.)	1	4. Race - Ame Black, Whit		
36	filed within 72 hours after death with the Maryland Hygiene. Ather than "netural", or Items 23a or 28e-1 show ant, the Medical Exentral must be rodified at	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 XYes	ive	1945_ 1947		1 🗆 Yes 2		Specify:				Specify: Bla	_	
8	thour stural	ed t	15. Decedent	Year or	Dates:		Dece	tent's Usual	Occupa	tion			16h Kin	d of Business	(Industry)	
715	nin 72 n "ne	Completed	(Specify only highest Elementary/Secondary (0-12)	t grade completed			(Give	kind of work DO NOT use	done di retired)	uring most	of worki	ng	100. KIII	d of Business	andustry	
22	filed withi Hygiene. other ther	Com	12	College	(1-4or 5+)	Cl	nauí	ffer					Limo	usine		
2		Be (17. Father's Name (First, Middle, L	.ast)						18. Mother	r's Name	(First, Middle,	Maiden S	Sumame)		
<u>X</u>	should be and Mental marked o	To E	James M			Holly			F	Rose	Н	elen		Young	7	
Maryland 21215-0036	2 should be and Mental remarked c		19a. Informant's Name/Relationsh			2.7						l Route Number				
e O	D ≅ Z ±		William Martin/E	3rother		370	019	New M	arke	et Rd		rlotte 1				22
0	00		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal from	I	Ob. Place of cemeter	y, cren	sition (Name natory or oth	e of er place)	E	ate	20c. Loc	ation - City or	Town, State	
altimore,			4 □ Donation 5 □ Other (Sp21. Signature of Funeral Service L		1	MD Vet			17170-0			4/04 C	helt:	enham,	Mary1a	and
Ba	permit. Departr Importe eny inje		DOWN O	LOA	,	MO1 222		. Name and		,				_		
.453			23a. Part1. Enter the disease, or o	complications that								P.A. Aqu		o,Maryl	Land Approximat	10
	Dhysisian		Immediate Cause (Final	only one cause on	each line.	ROIAL						. roopilatory arri	301,		Interval Bet Onset and	ween
7	Physician /Medical		disease or condition resulting in death)	a		nsequence of		10/20/2		2000						
	Examiner				(01 40 4 00	, rocquo, roc c	J1).									
-	T #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	(UI do a UU	i sounance c	oľ).									
	acute ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c												
Ö,	cate be executed physician and the buriat-transit		resulting in death) Last	Due to	orasaco	nsequence o	of):									
9/8	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	dicai	'	d												
X O	eath certific attending p	Physician/Me	IF FEMALE:	23c. If yes, or	itcome of n	regnancy										
ROX	atten I for u	cian	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2	Fetal death		Ectopic pred					23	Id. Date of deli Month		Year
o.	that the de ned by the a detached t	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unk			J_	Oli lar (Spac	,"y/				Í			
7	res that igned b	by PI	Part II. Other significant condition	s contributing to	death but no	t resulting in	the un	derlying cau	se giver	n in Part I.		23e. Did tob	acco use	e contribute to	the cause of d	leath?
ecords,	w require been sig should b	ed b	HYPERTENSION									1 🗆 Ye	s 2 🗆	No 3□Pro	obably 4 🗹	Ínknown
ပ္တ	aw requisite been 2 should	piet	DEMENTIA	DEPRES	SION	, ME	77	57476	C 13	out		24a. Was ar	1	24b. Were au	topsy findings	available
ř	0 = 0	Completed	CANCER CO	KEBROIT	cus	2 6	1	NWT			_	autops perform 1 Yes 2	red?	prior to death?	completion of ca 2⊟No	ause of
Vital K	ysician: Th	Bec	25. Was case referred to medical examiner?			7		GAGA-4		26. Place o	of Death	(Check only one		1 1 163	20 NO	
> 	Physician: r this certific ral director,	2	1□ Yes 2☑No			2 ☐ ER/Out	tpatient	3□ DOA	Other	4 Nurs	sing Hon	ne 5 ☐ Reside	nce 6 i	Other (Spec	ufy)	
	ding P	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date (Moi	of Injury oth, Day Yea	28b. T ar) In	ime of		: Injury : Work?	at	2	8d. Describe ho	w injury	occurred		
<u>s</u>	tend leath tor: /	cati	2 Accident investigated and Suicide 6 Could no	at ho				М		es 2 N						
UNISION	or All	ertification:	4 Homicide determin	ed 288. Plac	e of Injury - ling, etc. <i>(S</i>)	At home, far pecify)	m, stre	et, factory, o	office		2	8f. Location (Str City or Town	eet and i , State)	Number or Ru	ral Route Num	ber,
	pours ours inted	O	29a. Certifier 1 Certifying	Physician: To th	e hest of my	/ knowledge	doath	Occurred at	the time	data and						
	e Hos	edical	(Check only 2 Medical E. one)	xamıner: On the i	pasis of exame	mination and	/or inv	estigation, in	my opi	nion, death	occurre	d at the time, da	te and p	nd manner as lace, and due	stated. to the cause(s)
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Me	29b. Signature and title of certifier					29c. l	ıcense	number		29	d. Date	signed (Month	, Day, Year)	
			Dollar	Philit	0			1	500	763			01	1051	104	
	200		1			(Item 23a) (Туре, Р	Print)					/	,		
	33:11		30. Name and address of person w FUCTON (C) 31. Date filed (Month, Day, Year) JAN 0	119300	all),	AN	M	CHA	Rec	77 EK	FALL	, MI)			
	Sta	te	31. Date filed (Month, Day, Year)	7 2004 32.1	Registrar's S	Signature		1								
	Registra	11	37114 0	. 2007	MARIAN.	1 St.	14	De age	P							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** January 2, 2004 Donald S. Hall 12:02 AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner 2661 Solomons Island Rd. Edgewater Anne Arundel If Under 24 Hrs. 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funera! Months Days Hours 1 M 2 □ F Yrs. 214-46-4749 28,1946 Director 57 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🛣 No Funeral Director Maryland Anne Arundel Edgewater 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 2661 Solomons Island Rd. 21037 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: White Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher 5+ years Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harvey N. Hall Claire Stewart 2 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lillian H. Hall/ Wife 2661 Solomons Island Rd., Edgewater, MD 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 1-3-04 Edgewater, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical year Examiner Due to (or as a consequence of by Physician/Medical Examiner urrafter death.

wrate Director: After this certificate hes been signed by the attending physician and filled in by the funeral director, page 2 should be deteched for use es the bunal-trensit Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown Yes 2□ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 X No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Medical Certification: To 1 Yes 2 XNo 3□ DOA 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 12 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. the the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 Cenine Weiner 2,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wad #300 Jeanine

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year)

JAN 0 5

2004

8 Maryland 21215-0020 ohn son, Baltimore,

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 20043;50 P.M. Year **Physician** Robert Bachman Johnson January
4b. City, Town, or Location of Death /Medical 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner Glen Burnie Anne North Arundel Hospital Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 72 Yrs. Director 203-26-4236 30, 1931 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov MD Anne Arundel Severna Park 1 ☐ Yes 2 No Director 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code ŏ 405 Severnside Drive USA 21146 Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 □XYes 2 □ No If Yes, Give Korea Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 X Married White "natural", or 1 ☐ Yes 2 ZÃNo Specify: Korea δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 2 should be filed within 7: end Mentel Hygiene. Is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Computer Scientist Federal Govt. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) end Mentel F Alfred W. Johnson Harriett Bachman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Johnson/Wife 405 Severnside Drive, Severna Park, MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Pages 1 Depertment of Important: If it eny Injury or c Jan. 3, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD Metro Crematory 2004 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Ho 495 Gov. ritchie Hwy, Severna Park, MD 21146 234 Part1 Enter the disease, or commerciations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Grenn attending physician end for use es the bunel-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 20 No 3 Probably 4 Unknown Š 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy s certificate hes b director, page 2 s 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ours after death.

nerel Director: After this y filled in by the funerel di 27. Manner of Deat 28b. Time of 28d. Describe how injury occurred Medicai Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funerel D
completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated To the

State

Registrar

DHMH 16 Rev 6/95

JAN 0 6 2004

29b. Signature and title of certifier

gypky Okisvin

30. Name and iddress of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item//9 per State of Maryland / Department of Health and Mental Hygiene For Fun.Dir. 1/9/04 BHM AACO. Health Dept Certificate of Death Reg. No. Amend Item/19 per 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Gustav E. Jackson 2004 January 4:18 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Annapolis
If Under †Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | March | 3 10 Anne Arundel Medical Center Anne, Arundel Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** 1**⊠** M 2□ F Yrs Director 58 1945 South 360-42**-**0146 Usuel Residence of Decedent Guyana the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examinar count be notified at 1₺ Yes 2 No Maryland Anne Arundel Shady Side 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Items 23s or 1725 Columbia Beach Road 20764 death by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Geologist 9 yrs Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Stonewall Jackson Winifred Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Megan Jackson (Wife) 1725 Columbia Beach Rd. Shady Side, Md.20764 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory 1/5/04 Baltimore, Md. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Reese & Sons MOrtuary, West St. Annapolis, Md Wm. Larry D. Jase Mas 48) 821 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 out 000 **Physician** /Medical Due to (or as e consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Box 68760, by Physician/Medical as the IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, page 2 should be 3 Probably 4 Unknown 1 Yes 2 700 Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 0 No 1 🗌 Yes Division of Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 × NO Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient THUR 1 🗌 Yes 2 ER/Outpatient Certification: To this in by the funeral 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 6 Could not be determined 3 Suicide Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide Pellij 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the 29b. Signature and title of dertife 29c. License number signed (Month, Day, Year) ma cause of death (Item 23a) (Type Frint) and address of person who completed 2002 2140

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

JAN 0 5

32. R

2004

			For State Registrar	State of N	-	epartment of Health Certificate of Death		iene 2001	00953
	Physici	an	1. Decedent's Name (First, Midd Elmer		obert	Kellough,	2. Date of Dear Month	Day Year	3. Time of Death
	/Medio Examin		4a. Facility Name (If not institution			4b. City, Town, or Location	Gairdary	3, 2004 4c. County of Dea	7:03 P
	Examin	IGI	Devlin Manor	•		Cumberlar	ıd	A11	egany
	Funeral		5. Social Security Number	6. Sex 7. A	Age (In yrs. last birth	Months Davs Hours	24 Hrs. 8. Date of Birth Min. (Month, Day	O Bie	thplace (State or Foreign
	Director		2 2 0 - 0 9 - 0 0 9 2 Usual Residence of Decedent	IMM ZUF	88 Yı	S.	07/24/19	915 Wes	t Virginia
	land ow		10a. State 10b. Count	у	10c. City, Town	or Location			10d. Inside City Limits
	Mary Ited	ţ	MD A	.11egany	Cur	berland			1 ∑Yes 2 ☐ No
	or 28c	irec	10e. Street and Number	3		10f. Zip Code	1	0g. Citizen of What Co	ountry?
	23a c	a	1706 Frederic	k Street		21502		USA	
	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "natural", or items 23a or 28e-f show event, the Medical Examinal must be notified at	Funeral Director	11. Marital Status	12. Was Deceder Armed Force	\$?	 Was Decedent of Hispanic Or If Yes, specify Cuban, Mexica 	igin? (Specify Yes or No- n, Puerto Rican, etc.)	14. Race - Ame Black, Whi	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Ma 3 ☑ Widowed 4 ☐ Divorce	If Yes, Give		1 ☐ Yes 2 ☒ No Specify	:	Specify:	White
P	2 hou	ted	15. Decede	ent's Education	16a. D	ecedent's Usual Occupation		16b. Kind of Business	
215	filed within 72 Hygiene. Hyer then "na ent, I're Medic	Completed	(Specify only high Elementary/Secondary (0-12)	est grade completed) College (1-4o		Give kind of work done during mos ife. DO NOT use retired)	st of working		
Maryland 21215-0036	filed with Hygiene. other ther ent, the N	5	12	6		Pharmacist		Healthc	are
<u>n</u>	tal H	Be	17. Father's Name (First, Middle				er's Name (First, Middle, I		
<u> </u>	permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked on ery injury or other traumatic events.	은	Elmer R 19a. Informant's Name/Relation	obert	Kellough,	Sr. Lucy Aailing Address (Street and Numb			Phares
<u>B</u>	d 2 st th and 7 Is r traur	3	Steven Kelloug			300 SW 120th St		•	ZIP COOB)
	Heal Heal tem 2		20a. Method of Disposition	511 / 3011	20b. Place of D	isposition (Name of		20c. Location - City or	Town, State
ē	bages ant of nt: If if		1X_XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (9	crematory or other place) Memorial Park	01/08/2004	Cumberlen	4 MD
Baltimore,	mit. F partme portar injur		21. Signature of Fun and Service		Journset	22. Name and Address of Facility	Security of the Control of the Security of the		_4
m	e a E e a		Labort (. asken	-	404 Decatur S		•	21502
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that caus st only one cause on each	ed the death. Do no line.	t enter the mode of dying, such as	cardiac or respiratory arri	est,	Approximate Interval Between
В	Physician		Immediate Cause (Final disease or condition	6	Brain	Tumor			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	is a consequence of		-1-0-2-0		
	Examine		Sequentially list conditions,	b	is a consequence of				
_	ted nsit	ig ig	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	10) 01 800	is a consequence of				
	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or a	is a consequence of	:			
8760,	e be siciar	dical		d					
9	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edi	1-30			w			
Вох	death certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ie of pregnancy 2 Fetal death	3 ☐ Ectopic pregnancy		23d. Date of de	•
	e dea he att	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No		at time of death	5 Other (specify)		Month	Day Year
<u>о</u> .	that the de led by the a detached	Phy	9 Unknown	lians contributing to dooth	but not reculting in t	he underlying cause given in Part	23a Did tol	pacco use contribute to	the cause of death?
	ires tha signed I I be det	þ	į į	ten sion	Q a	nal Faitui		as 2□No 3□Pi	~ '
Š	v require been sig should t	etec	1791		1	J. J. J. J. J. J. J. J. J. J. J. J. J. J	24a. Was a		stance findings available
Be	The lav	Completed by					autops perforr	y prior to	utopsy findings available completion of cause of
ā	iicien: Th certificate rector, pag	ပို	25. Was case referred to medic	al		26 Pine	1 ☐ Yes 2 e of Death (Check only on		2 □ No
>	Physicien: this certificatal director, p	To B	examiner?	Hospital: 1 ☐ Inpa	tient 2 ER/Outp	Othor	ursing Home 5 Reside	-	cify)
Division of Vital Records,	g Phy ter thi		27. Manner of Death	28a. Date of In	F1.5	ne of 28c. Injury at		w injury occurred	
Ö	andin ath. or: Aft	atio	2 - 7 100.00.11	tigation	,	M 1 Yes 2	No		
ž	or Attendented irecton by the	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	mined 200. Flace of I	njury - At home, farn etc. <i>(Specify)</i>	n, street, factory, office	28f. Location (St. City or Town	reet and Number or Ri n, State)	ural Route Number,
Ω	urs af		20 0 11						
	Hosp 24 ho Fune Fune	Medical	29a. Certifier IXXCertify (Check only one)	ing Physician: To the bea at Examiner: On the basis and manner	of examination and/	death occurred at the time, date ar or investigation, in my opinion, dea	nd place, and due to the ca ath occurred at the time, da	ause(s) and manner as ate and place, and due	s stated. to the cause(s)
	To the Hospital or Attending Pt within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Mec	29b. Signature and title of certifi			29c. License number	2	9d. Date signed (Mont	h, Day, Year)
			1	20 - 1		D21244		January 5,	2004
6	IVA		30. Name and address of person	n who completed cause of	death (Item 23a) (T	ype, Print)		J - 7	
7	115		Jesus H. Ta			eorges Creek Roa	(Suite 3)	sthure. MD	21532
	Sta		31. Date filed (Month, Day, Yea	r) 32. Regis	strar's Signature		,		
	Registi	rar	JAN 0 5	ZUU4 "	1	pouls			

			Please	Type or Prin				·		•	
			1 _ State	State of Ma	ryland	•	tment of Health ficate of Deat			- 21111	1 011954
			Registrar 1. Decedent's Name (First, Middle, La	ef)		Ceru	ilcale of Deal	2. Date o	Reg. I	No.	3. Time of Death
	Physici		Jane M	KI	100	(1		Month		bay Year	11.55 AM
	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)	,,	9	b. City, Town, or Location	on of Death	1/	4c. County of Dea	
	LAGIIIII		Atlante G	eneral t	1050	tal	Berlini	Maylas	20	Werce	5ter
	Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. la	2	If Under 1 Year If Und	der 24 Hrs. 8. Date of	Birth Day, Yea	ar) 9. Bi	rthplace (State or Foreign country)
	Director		000-00-1141	IM 2004	/	3 Yrs.		8/1	4/5	30	MD
55	and		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loca	tion	•			10d. Inside City Limits
1	Mary]	ğ	MD Worce:	ster		Berlin					1XYes 2 No
46	n the	Director	10e. Street and Number				10f. Zip Code		10g. (Citizen of What C	country?
116/2004	death with the Maryland sms 23a or 28e-f show ir must be rediffed at	a D	9715 Health	way Dr.			21811		1	USA	
6	r dea	by Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		. 13. Wa	s Decedent of Hispanic es, specify Cuban, Mexi	Origin? (Specify Yes o can, Puerto Rican, etc.	No-	14. Race - Am Black, Wh	erican Indian, ite, etc.
986	s afte	Y.	1 ☐ Never Married 2 ☐ Married XXividowed 4 ☐ Divorced	1 Tes 2 XN	0		Yes 2 No Spec			Specify: W	
8 8	within 72 hours after dea ene. than "neturel", or Items is Medical Evaruh et III	a pa	15. Decedent's E	Year or Dates:		16a Deceder	it's Usual Occupation		166	. Kind of Business	
8/16/1930 d 21215-00	n ne	Be Completed	(Specify only highest gra	ade completed)		(Give kii life. DC	d of work done during π NOT use retired)	nost of working	100.	. Itilia of Dasilles	a made ii y
76/ 212	with giene.	Eo	Elementary/Secondary (0-12)	College (1-4or 54	-)	Hospit	ality Specia	alist		Restaura	ant
Ø ₽	e file al Hyg l'othe vent.	3e C	17. Father's Name (First, Middle, Last,)		· · · · · ·	18. Mc	other's Name (First, Mic		,	
. M. 8/16/1936 - 1 -1864 aryland 21215-0036	Menta Menta arked	10	Alfred Norman					Jane Reid	Vena	able	
Jane M	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene. item 27 Is marked other than "neturel", or Items 23a or 28e-f show other traumatic event. If a Medical Everul er mast be recitived at		19a. Informant's Name/Relationship (Type, Print)			Address (Street and Nur				Zip Code)
6, M	1 and Health em 27 ther tr		Robin Shipley 20a. Method of Disposition		20b. Pla		Box 683 Sell			975 Location - City o	r Town State
100	Pages nent of int: If it		1 ☐ Burial 2 【XCremation 3 ☐ *4 ☐ Donation 5 ☐ Other (Specif	Removal from State			on (Name of lory or other place) lopen Crema	1/8/84°		rankfor	
Kilray, Ju 220- Baltimore			21. Signature of Funeral Service Licer		Car						
B Z	permit. Departr Importe eny injt		Managed in	TRALL	olto	. 10	lame and Address of Fa	The Burba	ige r MD	-unerai 21811	ноте
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death.						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	PACIL			lar ac		,		Onset and Death
	/Medical		resulting in death)	Due to (or as a				-0(00-17			
	Examiner	L	Sauuentially list conditions,	b							
	ed sit	Examiner	Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	. conseque	ence of):					
	te be executed ysician and te burial-transit	xan	that initiated events resulting in death) Last	c Due to (or as a	conseque	ence of);				_	
760,	sician buriz	7		4							
687	eath certificate attending phys I for use as the	edlc		- d							
ŏ	n certi	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of			topic pregnancy		10	23d. Date of de	alivery
B	the atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at t			ther (specify)		_	Month	Day Year
P.0	that the de ed by the detached	h	9 🗆 Unknown								
s,	res th	Completed by Physician/Medl	Part II. Other significant conditions of	CPS 0: (A	t not result	ting in the und	erlying cause given in Pa				o the cause of death?
õ	requi	eted	10,000000000	013	10,	7	410, 0	-	-		
3ec	e law has t	du	Capa logiter	1100				a	Vas an utopsy erformed?	prior to	utopsy findings available completion of cause of
<u>a</u>	n: Th ficate r. pag	ပိ	John tallo	N				1 □ Ye	s 2 🖼		s 2 10 No
₹	sicia s certi lirecto	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	t 2□F	R/Outpatient	Othor	ace of Death (Check or Nursing Home 5 7 F	== 2 = SHS(V	6 DOther (Sec	nc/fu)
ō	g Phy er this eral c	n: To	27. Mann Death	28a. Date of Injury (Month, Day		8b. Time of	28c. Injury at Work?			jury occurred	scily)
<u>i</u>	ath. rr: Aft	atio	1	n	1041)	Injury	M 1 Yes 2	□No			
Division of Vital Records, P.O. Box 68	or Attending Physician: The law requires that the death certificate be execut the death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-trar	Certification;	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of Injurbuilding, etc.	ry - At hom (Specify)	ne, farm, stree	, factory, office	28f. Location City or	n (Street a Town, Sta	and Number or A	lural Route Number,
۵	ital o										
	Hosp 24 hou Fune fune	Medical	29a. Certifier 1 Certifying Pt (Check only 2 Medical Exar	nysician: To the best of miner: On the basis of and manner stat	examinatio	ledge, death o on and/or inve:	ccurred at the time, date tigation, in my opinion, o	and place, and due to death occurred at the tir	he cause ne, date a	(s) and manner a and place, and du	s stated. e to the cause(s)
_	To the Hospital or Attending Physician: The law requires tha within 24 hours after death. To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be de	Mec	29b. Signature and title of certifier	and maintai stat			29c. License numbe	er .	29d. [Date signed (Mon	th, Day, Year)
	⊢≤⊢ō		* Kustine e	Jush.	w		C1-0001	6795	11	12/04	-
			30. Name and address of person who	complet cluse of de	ath (Item 2	23a) (Type, Pr	nt)			101	
\mathcal{C}	,H,4		KRISTINE GR	FRIN, W	10	1200	COASTA	1 HI6 Ke	My	FERL	MCK ISLAND
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registra	r's Signatu	le Soa	19		100/	1994	9

DHMH 17 Rev 1/2001

_			1 - For State Registrar	State of M	laryland / D	epartm		ealth and N	Mental Hygi	-)4	00955
	Physici /Medio		Decedent's Name (First, Middle ALBERT TH		HELY, S	R.			2. Date of Death Month	Day	Year 004	3. Time of Death 5:45 A M
	Examir		4a. Facility Name (If not institution, Atlantic Gener)	4b. C	Berlin			4c. County		
And the second	Funeral Director		5. Social Security Number 297-09-2732 Usual Residence of Decedent	6. Sex 7. Ag	ge (In yrs. last birti	rs. If Un Mont		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 5 / 19 / 1	Year) 914	9. Birthpl Count	ace (State or Foreign try) PA
	death with the Maryland ims 23a or 28a-f show I must be notified at	tor	10a. State 10b. County	cester	10c. City, Town	or Location					10	Od. Inside City Limits 1 X Yes 2 □ No
	th with the	al Director	10e. Street and Number 3 Decatur	St.		10f.	Zip Code	11	10	g. Citizen of W		ry?
9600	172 hours after death with the Maryla "natural", or tlams 23s or 28s-f shov scical Esseminar must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married	12. Was Decedent Armed Forces? 1 X Yes 2 If Yes, Give Year or Dates:)		cedent of His pecify Cuban		ecify Yes or No- Rican, etc.)	14. Race	· America c, White, e	
21215-0036		Completed by	15. Decedent' (Specify only highest Elementary/Secondary (0-12)	s Education grade completed) College (1-4or	5+)	(Give kind of life. DO NO		ion ring most of work	ing 1	6b. Kind of Bus		
land 21	s 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. Item 27 Is marked other than "natural", or ita other traumatic event, II a Mudical Examina	To Be Co	12 17. Father's Name (First, Middle, L Joseph Albe	•		Postal	Clerk		e (First, Middle, M Pistrak		-	ernment
Mary	1 and 2 shoul Health and Mi em 27 is mari	F	19a. Informant's Name/Relationsh Josephine T.	ip (Type, Print)					al Route Number,	City or Town, S	State, Zip (Code)
Baltimore, Maryland	Page nent o ant: If ury or		20a. Method of Disposition 1 X Burial 2 □ Cremation 1 4 □ Donation 5 □ Other (Sp	3 □Removal from State	20b. Place of cemetery	Disposition (f	lame of r other place)		Date 2	Oc. Location - 0		m, State
Balt	permit. Departr Importa any inju		21. Signature of Fund Service L	Tural	-	108 W	and Address	ine B St. Ber	urbage l lin, MD	Funeral 21811		ıe
	Pnysician /Medical Examiner		23a. Part1. Enter the disease or or or shock, or heart failure. List of the disease or condition resulting in death)	aa.	a consequence of	1		such as cardiac		st,		Approximate Interval Between Onset and Death
		icai Ex	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of							
Chevil 1	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 ⊟Ectopic 5 ⊟ Other (74.	23d. Date Mont		y Day Year
Je. t	v requires that been signed t should be deta	ρχ	Part II. Other significant condition	s contributing to death b	ut not resulting in I	he underlying	cause given	in Part I.				cause of death?
OUT -	The ate his page	Completed							24a. Was an autopsy performe	d? de	ere autops or to comp ath? Yes 2	sy findings available pletion of cause of
Afrenel Bivision of Vit	Attending Physician: r death. sctor: After this certific by the funeral director.	To B	25. Was case referred to medical examiner? 1 Yes	28a. Date of Inju (Month, Day	ont 2 EP/Outp ry 28b. Tir y Year) Inji	ne of	OOA Other: 28c. Injury at Work?	4 Nursing Hor	n (Check only one) me 5 ☐ Resident 28d. Describe how	ce 6 Other		
á	Hospital or Att		3 Suicide 6 Could no determin	ed 28e. Place of Inju- building, etc					28f. Location (Stre City or Town,	State)		
	To the Mospital or a within 24 hours after To the Funeral Dire completely filled in b	Medical	29a. Certifier (Check only one) 2□ Medical E. 29b. Signature and title of certifier	Physician: To the best of caminer: On the basis of and manner sta	examination and	or investigation	d at the time, on, in my opini 9c. License n	on, death occurre	ed at the time, date	se(s) and mann a and place, an . Date signed (d due to th	he cause(s)
			30. Name and address of person w	no completed cause of d	Try 5/C/1 eath (Item 23a) (T	ype, Print)	440	1283	1/	16/04	/	21811
0.	H,5+ Star Registra	te ar	31. Date filed (Month, Day, Year) JAN 7	2004 32 Registra	ar's Signature	Hez Sparki	Mha l	19 21	157	Berl	h~	40

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State AACO HEALTH DEPT. 1/6/04 OMH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2, **Physician** Barbara Ann Kral Month January 2004 /Medical 4a. Fecility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Maryland Medical University of
5. Social Security Number 6. S Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 6 Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign
 Country) 158-44-0433 1 M 2 F 53 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28e-f show 10d. Inside City Limits other traumatic event, the Medical Exeminer must be notified at ANNE Arunde Director 1 ☐ Yes 2 1 No VETNA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Ric or items 23a USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Š 1 ☐ Yes 2 ☑ No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home rtment of Health and Mental Hygintent: If Item 27 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ed bluods John E. Hooke Phyllis Ruegger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Donald Kral/Husband 8 Ridge Road Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State January metro Crematory or other p 1 ☐ Burial 2 XCremation 3 ☐ Removal from State permit. Pag Department Importent: I any injury o * 4 ☐ Donation 5 ☐ Other (Specify) 2004 Baltimore, MD 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Barranco & Sons, P.A. 495 Gov. Ritchie Hwy. Severna Park Funeral Home Severna Park, MD 21146 art1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Malignant Brain Tumar **Physician** ticease or condition ureck resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and I-transit death certificate be executed Due to (or as a consequence of) physician a P.O. Box 68760, Physician/Medical ası IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy lor in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has page 2 certificate 1 Yes 2 No 2 🗆 No 1 Yes or Attending Physician: ector, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral dir this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation within 24 hours after death. To the Funerat Director: A 2 Accident the f 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 - Homicide Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifie To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P16602 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

JAN 0 6 2004

lilliam

ORIGINAL

Rchan

32. Registrar's Signature

University of Manyland Medical Center

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Catherine S. Kaplan January 3, 2004 2:20 P /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heartlands of Severna Park Severna Park Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) **Funeral** Hours 1 M 200 Yrs. Ĩ916 Director 87 215-52-5488 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow d other than "natural", or items 23a or 28a-f ehovevent, the Modical Examiner must be notified at 1 ☐ Yes 2 XNo Director Maryland Spencerville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15920 Batson Rd. 20868 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. fited within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: 3 XWidowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home if Health and Mental Hygi Item 27 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be 10 Alexander Stirling Kate Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David J. Kaplan / Son 15920 Batson Rd., Spencerville, MD 20868 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If It eny injury or o tment of 1 ☐ Burial 2 【GCremation 3 ☐ Removal from State • 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 1-5-04 Edgewater, MD permit. 21. Signature of Fyneral Sep 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last ng physician ar Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 10 in the past 12 morths? Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has irector, page 2 autopsy of Vital 1 ☐ Yes 2 or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 🗆 Yes Hospital: Other: 4 Nursing Home 5 Residence 200 Medical Certification: To 1 Inpatient 2 ER/Outpatient 3□ DQA funeral dir Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manney f Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Division 1 Matural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death Accident the 6 ☐Could not be 3 Suicide in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide within 24 hours a To the Funeral C Hospitel pelil 1 dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifiei completely and manner stated. o the 29b. Signature and title of certifier 29c. License number 50725 le terans thuy Mille isville 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) 8601 redit 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2004

ORIGINAL

			For State Registrar		State	of Maryl	and / Dep	artmer			and M	ental Hy	/giene	ZUUL	00958
N.J	# 5		Decedent's Name (First, Middle	e, Last)								2. Date of D	eath		3. Time of Death
	Physici		Toni Fritz La	ahnie								Month Januar	Da:	2004	10:55p м
<u> </u>	-/Medic Examin		4a. Fecility Name (If not institution			umber)		4b. City	Town, or	Location of	of Death		-	. County of Deet	h
			1115 Outer Dr	ive				На	gerst	own				Washin	gton
	Funeral		5. Social Security Number	6. Sex	/ 2□F	7. Age (In	yrs. last birthda	/) If Unde Months	r 1 Year Days	If Under Hours	Min.	8. Date of B (Month, D	ay, Year)	9. Birti Co	hplace (State or Foreign untry)
	Director		212-38-8914	I LAIN	/ ZUF	L	74Yrs.					Octobe	r 28	,1929 (Germany
	and w		Usual Residence of Decedent 10a. State 10b. County			10c	. City, Town or	Location							10d. Inside City Limits
	f sho	5	Maryland Was	hingt	ton		Hagers	own							1 X Yes 2 ☐ No
	188- 288-	rect	10e. Street and Number				nagoro		Code				10g. Cit	tizen of What Co	untry?
	3a or	Ö	1115 Outer D	rive				2	1742				U	SA	
	within 72 hours after death with the Maryland ene. Than "hatural", or items 23a or 28a-f show the Madical Examiner must be mutified at	Funeral Directo	11. Marital Status	12	. Was De	cedent Ever	in U.S. 13	. Was Dece	dent of Hi	ispanic Ori	gin? (Spe	cify Yes or N	lo-	14. Race - Ame	
9	or ite	Ē	1 ☐ Never Married 2 🔀 Mar	ried	Armed F 1 ☐ Yes If Yes, G	2 T No		1 ☐ Yes		Specify:	i, Fuento	Rican, etc.)		Black, White Specify: Wh	
8	rai'.	d by	3 Widowed 4 Divorced		Year or	Dates:		10.00	24.10	ароспу.					
ν. V	natu Olca	Completed	15. Deceder (Specify only highe			"	(Giv	edent's Usu e kind of w DO NOT a	rk done d	during mos	t of worki	ng	16b. K	ind of Business/	Industry
<u> </u>	Mithin ne. han	ш	Elementary/Secondary (0-12)		College	(1-4or 5+)		ninist		')			Ma	ck Truck	,
7	tygie ther t	ပိ	17. Father's Name (First, Middle,	(ast)			Maci	IIIIIS	·	18. Mothe	er's Name	(First, Middle			
Maryland 21215-0036	ntal l	Be c	Fritz Lahnig	,								Kosch			
<u></u>	mark mati	ို	19a. Informant's Name/Relations	ship (Type	e, Print)		19b. Ma	iling Addres	s (Street a					or Town, State, 2	Zip Code)
N N	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menial Hygiene. Important: if Item 27 is merked other than "natural; or Items 23a or 28a-1 ahow any injury or other traumatic event, the Medical Examiner must be nutitied at ance.		Ruth Lahnig/W	ife			1111	0ute	r Dr	ive.	Hage	rstown	. Md	. 21742	2
Baltimore,	s 1 a of Hea othe		20a. Method of Disposition			20	b. Place of Dis				-	ate	-	ocation - City or	Town, State
Ë	Page nent o int: If		1 ☐ Burial 2 【文Cremation 1 ☐ Donation 5 ☐ Other (5		moval fron	n State	Smithsb			1	1/5/	2004	Smi	thsburg.	Maryland
alti	permit. Departmine imports any injuica.		21. Signature of Funeral Service	Licensee	0	1000	7/7	22. Name a	nd Addres	ss of Facilit	y Re	st Hav		uneral (
m	8 5 € 8		7.1	<u>L</u>		_	4:	1601 E	enns	y1van	ia A	venue,	Hage	erstown,	Md. 21742
			23a. Part1. Enter the disease, o shock, or heart failure. List	r complicationly one	ations that cause on	caused the deach line.	death. Do not e	nter the mo	de of dyin	g, such as	cardiac c	r respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			Heas	Lecel	lie	10	(bur	m	me			Onset and Death
	/Medical Examiner		resulting in death)		Due to	(or as a cor	nsequence of):								0
Н	Examiner	_	Sequentially list conditions,	b.	196.16.6		w								
	ed sit	Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	₹ .	D09 10	o for as a cor	reequence of):								
	and al-trar	xan	that initiated events resulting in death) Last	с.	Due to	o (or as a con	nsequence of):								
3760,	ate be executed hysician and the burial-transit	cai E													
687	ificate g phy as the			0											
Вох 68	death certifica e attending ph id for use as th	2	IF FEMALE: 23b. Was decedent pregnant	230		utcome of probinth 2 1		Ectopic p	roonanov					23d. Date of deli	
	that the death certifica ed by the attending ph detached for use as th	by Physiclan/Med	in the past 12 months? 1 □ Yes 2 □ No			gnant at time		Other (s						Month	Day Year
P.O.	at the by th	hys	9 Unknown												
Ś	8 5 0	by	Part II. Other significant conditi	ons contr	ibuting to	death but not	t resulting in the	underlying	cause give	en in Part I	•			_	the cause of death?
D.C	w require been si should I	ted										10	Yes 2	QNo 3□Pr	obably 4 Unknown
Vital Records,	las b	Completed										24a. Wa auto	psy	prior to c	topsy findings available completion of cause of
<u>=</u>	hysician: The law his certificate has t I director, page 2 s	ပ္ပ											lómáed? 2 ⊠ No	death? 1 ☐ Yes	2 No
Žį.	ician certifi ector	B	 Was case referred to medical examiner? 		snital:	- 0579-5			Oth			(Check only			
o	Phys this al dir	2	1 ☐ Yes 2 ☐ No Manner of Death				2 ER/Outpati		OA Inun	4 □ Nu	irsing Ho	ne 5 Res 28d. Describe	how iniu	6 □Other (Spec	cify)
E O	ding h. After funer	to	1 Natural 5 ☐ Pendi	ng igation	(Mo	e of Injury onth, Day Yea	ir) Injury	м.	28c. Injun Work	k? Yes 2□			11011 1111	, y 000an 00	
Division of	Attending it death.	flca	3 Suicide 6 Could	not be	28e. Plac	ce of Injury -	At home, farm,	street, facto			-				ral Route Number,
ă	after after Directory	Certification;	4 Homicide	,	buil	ding, etc. (Sp	oecify)					City or To	own, State	9)	
	To the Hospital or Attending Phy within 24 hours atter death. To the Funeral Director: Atter thi completely filled in by the funeral		29a. Certifier 1 Certifyi	ng Physic	cien: To th	ne best of my	knowledge, de	ath occurre	at the tim	ne, date ar	d place,	and due to the	e cause(s)) and manner as d place, and due	stated.
	he H in 24 he Fi	Medical	one)	Examine	and ma	nner stated.	mination and/or				un occurr	ed at the time			
	To the within 2. To the I complet	Σ	29b. Signature and title of certific	"	2000			29	c. License			,	29d. Da	te signed (Month	n, Day, Year)
7	6		V Nous L		Tree	7			P	220	16	pend-		1/2	101
L	#		30. Name and address of person	who com	eleted car	use of death	(Item 23a) (Typ	e, Print)							
7	Sta	ite	31. Date filed (Month. Day, Yeen	L _ = -	_ 32	Registrar's S	Signature	1 1							
	Regist		31. Date filed (Month, Day, Yeer	5 200	4 1	decur	Signature	perte							

			For Stata Registrar	State of N	Maryland		artmen rtificate			and M	lental Hyg	iene _{9. No.} 20	Party on Towns	0095	C
	Physici	an	1. Decedent's Name (First, Middle, Last JOSHUA COWEL		IELD						2. Date of Deat Month	Day 200	Year 4	3. Time of Death 9:30 A	I
	/Medic Examin	er	4a. Facility Name (If not institution, give 12615 Sheppards 5. Social Security Number 6. Se	street and numbe	r)	st birthdav)		naley	Location of	JCW.	8. Date of Birth	4c. County	of Death	er	
	Funeral Director]M 2□F	83	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, 7 / 22 / 19	20 20	Cou	place (State or Foreign ntry) MD	
	the Maryland 28a-f show ctiffed at	ector	10a. State 10b. County MD Worces 10e. Street and Number	ter		Town or Lo		Code			11	og. Citizen of W		10d. Inside City Limits 1 ☐ Yes 2 🛣No	
	3a or	i Dir	12615: Sheppards	Crossin	g RD		1.2.1.2.4	1872				USA		y.	
9036	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show dical Exemitier must be notified at	d by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Nover Married 4 Divorced	12. Was Deceder Armed Force 1 Tyes 2 If Yes, Give Year or Dates	s? ∑ No		1□ Yes	21 X No	Specify:	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)	Specify:	k, White, Whi	ite	
Maryland 21215-0036	within ane. then "	Completed by	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-40	r 5+)	(Give life.	dent's Usua kind of wor DO NOT us	al Occupa rk done d se retired,	ition luring mos)	t of worki	ng	16b. Kind of Bu Farm		dustry	
ק סר	filed Hygi other	BeCc	17. Father's Name (First, Middle, Last)					T			(First, Middle, M	Maiden Sumam			
ylar	should be nd Mental marked o	10 E	Winder Cowell I			101 11 11	·	(0)			Mae Mit		O4-4- 70	- 0 - 4 -)	_
Baltimore, Mar	es 1 and 2 and 2 of Health ar f Item 27 Is		19a. Informant's Name/Relationship (T. Cordellia Jean 20a. Method of Disposition 1 ★Burial 2 □ Cremation 3 □	Bozman	te ce	748 ace of Dispo	35 Ma osition (Nam matory or o	delir ne of ther place	ne Ci	rcle		sburg, 20c. Location - (MD City or To	21849 own, State	_
Ē	t. Partmer		4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service License)	Ne	w Hop						Willard			_
Ba	Depa Impo any ii		W. Kill	Julale			108 W	illia	m st.	ine Bei	Burbage rlin, MD	Funer 21811	al H	ome	
8760,	Ity edical Examiner /Medical Examiner physician and the prirat-transit the prirat-transit for the prirate for	Ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Dua to (or t	as a consequas a consequ	ence of je	de.	tu	se (3		ouery	Disca	26-	Onset and Death	
.O. Box 68	ath certifi attending I for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcon 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Fetal at time of de	death 3[Ectopic pr					23d. Date Mor		ery Day Year	
<u>α</u>	quires that the de n signed by the a	by	Part II. Other significent conditions co	ontributing to death	but not resu	Iting in the u	inderlying c	ause give	en in Part I		23e. Did tot	_		he cause of death?	ı
Vital Records,	The law requir sate has been si page 2 should	Completed									24a. Was all autops perform	ned?	eath?	opsy findings available impletion of cause of	,
/ita	icien: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?	Henrital.				Otho			(Check only on	1			_
oţ	ng Phys fter this meral dii	ation: To	1 Yes 2 No 27. Mann Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpa 28a. Date of in (Month, I	_	ER/Outpatie 28b. Time o Injury		8c. Injury Work	4 🗀 NU		me 5X Reside 28d. Describe ho			(y)	
Division	Dir	Certification:	3 Suicide 6 Could not be 4 Homicide determined	200. Flace 01	Injury - At hor etc. (Specify	me, farm, st	reet, factory	, office			28f. Location (St. City or Town		er or Run	al Route Number,	
	To the Hospitel within 24 hours of To the Funeral completely filled	edicai	29a. Certifier 1 Dertifying Phyone) 2 Medical Exemptons		of examinati										
	To the within 2 To the complet	Ž	29b. Signature and title of certifier	100			290	License	number	ic	2	ed. Date signed	(Month,	Day, Year)	
7				nompleted earns	of docth /line	22a\ /T	Print)	M3	16	18		115/	4		
DI	114		30. Name and address of person who of Joseph McShe	a. D.O.	10514	Race	track	RD	Berl	in.	MD 218	11			
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Fegi	strar's Signat	B A	book	,							

	Physiciai /Medica		Mary B. Le						Jan	1, 2004	Year	7:20 PM
أنص	Examine	_	4a Fecility Name (If not institution, giv		-				n, or Location of D			
			Civista Medi 5. Social Security Number 6. S		nter 7. Age <i>(In yrs. l</i> e:	et hirthday)	If Under 1 Ye		Plata 4 Hrs. 8. Date of		harle	
	Funeral Director	- 1		_м 2 ∕Срг	85	Yrs.	Months Da		Min. Aug.	19, 1918	West	oce (State or Foreign Virginia
	9	- 1	Usuel Residence of Decedent						11.04.51	,		
	show		10a. State 10b. County			Town or Lo					10	d. Inside City Limits
	Ne Me		Maryland Charles	5	l l	va 1 doi				T		1 ☐ Yes 2 💢 No
	with the	runeral Director	10e. Street end Number 823 Copley Avenue	2			10f. Zip Cod	20602		10g. Citizen of	Whet Count JSA	ry?
	Jeath Tre 23	era	11. Marital Status		dent Ever in U,S.	. 13. \	Was Decedent		n? (Specify Yes or Puerto Rican, etc.)		a - America	n Indian,
0	aftar or the		1 Never Married 2 Married	Armed For	dent Ever in U,S. rces? 2017 No	'	fYes, specify 0 1□Yes 20 X (1		Puerto Rican, etc.)		ck, White, e	tc.
005	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or tierns 23s or 28s-f show ont, the Medical Evandrer must be notified at	ה מ	3 X Widowed 4 ☐ Divorcad	If Yes, Giv Year or Da	e ites:		TLI Yes 2LAI	чо Зреспу:		Specify	y: Wh	ite
15-	netu	5	15. Decedent's Ed (Specify only highest gre	ducation de completed)		16a. Deced	dent's Usual Oc kind of work do	cupetion ne during most o tired)	of working	16b. Kind of B	usiness/Indu	ustry
112	withir ene. than	Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)		d Proce			Comr	outer	
P	Mantal Hygi Mantal Hygi arked other atic event, i	3	17. Father's Neme (First, Middle, Last)						s Name (First, Mid	dle, Maiden Surnan		
ılan	Anntal hantal	2	Michael Bohin					Fa	annie Buc	kko		
lan	2 should and Man is marke aumatic	ľ	19a. Informant's Name/Relationship (mber, City or Town,	Stete, Zip (Code)
3, ₹	1 and 1 Health sm 27 ther tr	- 1-	John R. Lehosky -	Son					Valdorf,			
Baltimore, Maryland 21215-0020	S -5 = 0		20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removel from S	State cen	netery, cren	sition (Name or natory or other	place)	Date	20c. Location -	(9075-5	n, State
Ħ	pamit. Page Department (important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licer				Memoria		1-6-04	Waldorf,	MU	
Ba	parm Depa impo any i	J	21. Signators of Puneral Service Licer	0	M00053			dress of Eacility neral Ho				
	-	-	23a Part 1. Enter the disease, or com	Lauran that ca	Jused the death	P. Do not entr	. O. Bo	x 156, W	Valdorf,	MD 20604		Approximate
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on ea	ach line.	DO NOT ON	or the mode of	dynig, such as or	ridiac or respirator	y onest,	į	Approximate nterval Between Onset end Death
	/Medical	1	Immediate Cause (Final disease or condition	M-	YOCAR	の n †	Δì	TNI	- ARC-	TION	İ	
-	Examiner		resulting in deeth)	е	Due to (or a	s a conseq	uenca of):	T 10 F	-1111	11000		
	D iii			, A7	HERO	, - S	CLEX	ROTIC	HEA	TION RT DIS	EASE	
	and Il-tran	7	Sequentially list conditions, if env. leading to immediate	J	Due to (or a	is a conseq	uenca of):					
60,	sician Sician bunia		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events	c								
687	ficata physas the		resulting in death) Last		Due to (or a	s e consequ	uence of):]	
Box 68760,	death certificate be assecuted the attending physician and ed for use as the burial-transit			d								
	he att		Part II. Other significant conditions of	ontributing to dea	ath but not resulti	ing in the ur	nderlying cause	given in Part I.	23b. D	id tobacco use co	ntribute to t	he cause of deeth?
P.0	The law raquiras that tha de tat has been signed by the a paga 2 should be datached it		SEPS1	2 =					1	□ Yee 2 No	3 🗆 Proba	bly 4 🗆 Unknown
ds,	signe d be d	5							24- 14		24h Mar	e eutopou findinos
Ö	v raquire been si should								24a. W	as an autopsy erformed?	avail	e eutopsy findings able prior to pletion of cause
Rec	The law raquiricate has been single paga 2 should									¬		eth?
ta			25. Was case referred to medical					26 Place o	f Death (Check on	☐ Yes 2 No	10	Yes 2□ No
Ž	Physician: rthis certific and director,)	examiner? 1 ☐ Yes 2 🕱 No	Hospital: 1 XIr	patient 2 EF	R/Outpetien	t 3□ DOA	Other:		esidence 6 🗆 Oth	er (Specify)	
0	ding Ph h. Aftar th funeral		27. Manner of Death 1 XNaturel 5 ☐ Pending	28a. Dete o (Month		8b. Time of Injury	28c. Ir	njury et Vork?		e how injury occur		
Sio	Attending in death.	3	2 Accident investigation 3 Suicide 6 Could not be					☐ Yes 2☐ No				
Division of Vital Records,	tal or Attending P rs aftar death. ai Director: Aftar t led in by the funers Certification:		4 Homicide determined	20e. Fleca	of Injury - At homog, etc. (Specify)	e, farm, stre	et, factory, office	ce		n (Street and Numb Town, State)	er or Rural I	Route Number,
	spital cours resident		29a. Certifying Phy	/sician: To the b	est of my knowle	edge, death	occurred at the	time, date and r	place, and due to the	ne cause(s) and ma	inner as stat	ed
	he Hospit in 24 hour he Funer pletely fill		(Check only 2 Medical Examone)	Iner: On the bas	sis of examination	n and/or inv	estigation, in m	y opinion, death	occurred at the tim	e, date and place,	and due to the	ne cause(s)
	To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the timedical Certification.		29b. Signature and title of certifier	huel	-acel	lla	29c. Lice	ense number		29d. Date signed		
			V, 7)		0		D	- 26064	4	01-0	2-	2004
5	211		30. Name end eddress of person who					2 (1	-1 - t - 1	T 11 MD	2062	0
U	B4 State		Vidyasagar Anm 31. Dete filed <i>(Month, Day, Year)</i>	_				z, chai	TOLLE !	Hall,MD	2062	
	Registrar		JAN 0 5	2004	beve s	y A	perke					

DHMH 16 Rev 6/95

		For State Registrar	State o	of Marylan		rtment of I	Health and Death		giene Reg. No. 2001	. 0096
		1. Decedent's Name (First, Middle,	Last)					2. Date of Dea	Day Year	3. Time of Death
Physici /Medic		Mildred	R.	Le	eary			January	/ 3, 2004	6.05 AM
Examin		4a. Facility Name (If not institution,		mber)			or Location of Deat	h	4c. County of Death	1
		Genesis Elder		7.4. //	14 t-t-41	LaPla		O. Data of Bird	Charles	- la - (Ohan Farina
Funeral Director		5. Social Security Number 146-03-2442 Usual Residence of Decedent	6. Sex 1 ☐ M 2 🌠 F	7. Age (In yrs. 89	Yrs.	Months Days		8. Date of Birt (Month, Da July 29	9, 1914 Trei	nplace (State or Foreign untry) nton, NJ
land		10a. State 10b. County		10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
Marylan -f show	to	MD Charl	es	W	aldorf					1 ☐ Yes 2 No
1 the	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of What Co	untry?
h with		1000 Campus Co	ourt			20602			U.S.A.	
deat	Funeral	11. Marital Status	12. Was Dec	edent Ever in U.	.S. 13. \	Vas Decedent of Yes, specify Cut	Hispanic Origin? (S	pecify Yes or No- to Rican, etc.)	- 14. Race - Amer Black, White	
burs after death with the Maryla ral', or Items 23a or 28a-f shov Enantral must be collited at		1 Never Married 2 Marrie	ff Yes, Gi	ve		I □ Yes 2 No	Specify:		Specify: Whi	te
nural.	d by	3 ₩ Widowed 4 □ Divorced	Year or E	Dates:		lent's Usual Occu			16b, Kind of Business/I	
in 72	lete	15. Decedent' (Specify only highest	grade completed)		(Give	kind of work done	during most of wo	rking	TOD, KING OF DUSINOSSY	ndustry
ified within 72 hours after death with the Maryland Hygiene. Hygiene then "natural", or Items 23a or 28a-f show ont, the Madisal Exameration to mail be mailled at	Completed	Elementary/Secondary (0-12)	Colfege (1-40r 5+)	Denta	al Assis	tant		Dentist Of	fice
e filed other	Be C	17. Father's Name (First, Middle, L	ast)						Maiden Sumame)	
should be nd Mental marked o	To E	Lewis Rudenste	in				Jennie	ur	ıknown	
d 2 should be filed within 72 hr and Mandla Hygiene. 7 Is marked other then "nature treumatic event, the Mayical	ľ	19a. Informant's Name/Relationsh	ip (Type, Print)						er, City or Town, State, Z	
and ealth m 27 her tr		Fred Leary - s	on	201- 0		hree Bea	ars Irail	, Ormono	Beach, FL	32174
Pages 1 nent of H int: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation		State	cemetery, cren	natory or other pla		The Party	-	
t. Pa rtmen rtant:		* 4 □Donation 5 □ Other (Sp 21. Signature of Furieral Service L			Mary'	s Cemete	ry 1-b-	2004	Bordentown,	NO
permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tret		21. Signature of Funeral Service L	Vete	1241 e_		Huntt Fu P.O. Box	ry 1-6- ess of Facility neral Hon 156, Wa ing, such as cardia	ldorf, MI	D 20604	
		23a. Pert1. Enter the disease, or on shock, or heart failure. List of	complications that only one cause on	caused the deat each line.	h. Do not ent	er the mode of dy	ing, such as cardia	or respiratory ar	rrest,	Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition	- VAL	ULAR	HEF	187 VIS	EBBYE V	Livin		xzevs
/Medical Examiner		resulting in death)	Due to	(or as a conseq	juence of):	11		0.0		12 51
	<u>_</u>	Sequentially fist conditions, if any, leading to immediate	b. Due to	(or as a conseq	uence of):	- 19hr	152.1	1) '	1 10160 11
red nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	P	NC ALA	Just)	Rena	l Dra	Mace	iner	* walks
cate be executed physician and the burial-transit	Exal	that initiated events resulting in death) Last	Due to	(or as a conseq	uence of):			11		
ysicia e bur	dical	9	d	•						
	ı e	IE EENALE.							7	
th cer tendir r use	an/h	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna birth 2 ☐ Feta		Ectopic pregnanc	су		23d. Date of deli-	very Day Year
The law requires that the death certificate has been signed by the attending page 2 should be detached for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4□Preg 9□Unkr	nant at time of d nown	leath 5□	Other (specify)			Monar	ouy rou.
hat th bd by detacl		Part II. Dther significent condition	ns contributing to a	death but not res	sulting in the u	nderlying cause o	ven in Part I.	23e. Did to	obacco use contribute to	the cause of death?
signe d be	d by		· ·			, , ,		101	Yes 21⊠No 3 Pro	obably 4 Unknown
w requir been si should	Completed							24a, Was	an 24b. Were au	topsy findings available
he lav	g E							autop perfo	osy prior to c ormed? death?	completion of cause of
in: Ti ificate or, pa	C	25. Was case referred to medical					26 Place of De	1 ☐ Yes ath (Check only o	No 1 Yes	2 No
s cert	0 0	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	ER/Outpatien	t 3 DOA			dence 6 Other (Spec	eifv)
erthii	<u> </u>	27. Manner of Death	28a. Date		28b. Time of fnjury				how injury occurred	
ath. Att	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investig	ation	in, bay roary	,,		Yes 2□No			
ol or Atter de l'Directo	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	200. Plac	e of Injury - At he ling, etc. (Specif	ome, farm, str fy)	eet, factory, office)	28f. Location (5 City or Tox	Street and Number or Ru wn, State)	ral Route Number,
To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edicai (xaminer: On the I						cause(s) and manner as date and place, and due	
To th within To the	₩	29b. Signature and title of certifier	118	\		29c. Licer	nse number	20	29d. Date signed (Month	D. Bay, Year)
	-	June	MRI	1 m	リノ	D	2060	4	113	(DY.
		30. Name and address of person v	who completed car	se of death (fter	m 23a) (Type,	Print)	1011	Jano	5 0,00	mc nz
Mb		21 Date filed (About Care	17. W	PATTI A	en Y	\ \ \ \ , \	WITL:	NO15 1-	,1000	0007
Sta	ate	31. Date filed (Month, Day, Year)	5 2004 32.	Registrar's Signa	L	1 .				

DHMH 17 Rev 1/2001

					waryland		tificate of	Death	•		004	00962
	Physic /Med		1. Decedent's Name (First, Middle, La Thomas Jefferson						January	5 ^{Dey} 20	04 ^{ear}	3. Time of Death 12:20 PM
	Exami		4e Fecility Neme (If not institution, giv Gladys Spellman N					4b. City, Town, or L Cheverly	ocation of Deeth		y of Deeth Ce Geo	rge's
	Funeral Director				Age (In yrs. la:	st birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birt	⁷ 1918	9. Birthple Virgi	ece (State or Foreign
	land		Usuel Residence of Decedent 10a. Stete 10b. County		10c. City,	Town or Loc	ation				10	d. Inside City Limits
	the Marylar r 28a-f ehow	ţŏ	MD Charles		Wal	dorf						1 □ Yes 2 ☑ 🚧o
	ith with the 23s or 28 ust be no	al Dire	10e. Street end Number 11080 Weymouth Co	ourt			10f. Zip Code 20603			10g. Citizen of United		
0200	within 72 hours eftar death with the Maryland ene. than "natural" or items 23a or 28a-f ehow he Maolcal Evandrian must be notified at	To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Merried 3 Noved 4 Divorced	12. Was Decede Armed Force 12 Yes 2 If Yes, Give Year or Date	es? □No 194	1 "	/es Decedent of I Yes, specify Cub ☐ Yes 2 No	Hispenic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Rad Bla Specif	ce - America ck, White, e White	tc.
21215-0020	permit. Pages 1 end 2 should be filad within 72 hours Depertment of Health end Mentel Hygiene. Important: If tem 27 is marked other than "natural; any folury or other traumatic event, the Madical Exa RADE.	ompletec	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		or 5+)	(Give k life. D	ent's Usual Occup ind of work done O NOT use retire Operato	during most of work d)	ing	16b. Kind of B		
Maryland	ould be filar Mentel Hyg Irked othe	To Be C	17. Fether's Neme (First, Middle, Last) William F. Massey	,				18. Mother's Name Laura SI		Maiden Suman	ne)	
Mar	d 2 sho thend 7 is ma traum		19a. Informent's Name/Relationship (1					and Number or Run				
	s 1 en f Healt ftem 2		Robert H. Massey 20e. Method of Disposition		20b. Plac		ition (Name of atory or other ple	ver Court		X, VIrg		
Baltimore,	Page ment o		1 M Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify	Removal from Sta	110			Cemetery	1/13/04	Chelte	nham.	MD
Balt		mv	21. Signature of Funeral Service Licen	ohauni) M0005:	22.	Name and Addre	ss of FacilityHunt Vashingtor	tt Funer	al Home	9	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or companies, or heart fellure. List only of Immediate Ceuse (Final disease or condition resulting in deeth)		onic		ostruc	true]		^		opproximate niterval Between priset and Death
60,	rificete be exacuted 1g physician end 18 the bunel-transit	al Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c	Due to (or a	s a conseque	ence of):					
Box 68760,		Physician/Medical	resulting in death) Last	d	Due to (or as	s a conseque	ence of):					
	e death the atte	sicie	Part II. Other significant conditions co	ntributing to death	but not resultin	ng in the und	lerlying cause giv	en in Part I.	23b. Did to	bacco use cor	ntribute to ti	ne cause of death?
ls, P.0	es that the de igned by the a be dateched f	Ā	Resperation	7 Eu	lens	e			1 (V)	s 2□No	3 ☐ Proba	bly 4□Unknown
of Vital Records,	The law requires that the death cerate has been signed by the attendir paga 2 should be dateched for use	Completed	Vento lux	DY 1	en	nd-	euco		24a. Was a perform	n eutopsy ned?	availa	autopsy findings able prior to eletion of cause eth?
tal			25. Was cese referred to medical						1 □ Ye	,	101	′es 2□ No
Ž		To Be	examiner?	Hospital: 1 Inpa	atient 2□ER	/Outpatient	3□ DOA Oth	26. Place of Death er: 4 ☐ Nursing Hor			er (Specify)	
o u	Jing Ph h. After th funeral		27. Menner of Deeth 1 ☑ Naturel 5 ☐ Pending	28a. Dete of Ir		b. Time of Injury	28c. Injur Wor	y at k?	28d. Describe ho			
Division	deat deat ctor: y the	flcat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of i	Injury - At home	farm stree		Yes 2□No	28f. Location (Sti	reet and Number	or Or Pum! E	Pouto Alumbor
Ω̈́	To the Hospital or A within 24 hours after To the Funerel Dire completaly filled in b	al Certification:	4 Homicide determined 29a. Certifier Check only 2 Maddical Every	building,	etc. (Specify)	dge death o	coursed at the tim	date and place of	City or Town	, State)		
	in 24 h	edical	(Check only 2 Medical Exami	ner: On the basis and manner	oi examination	end/or inves	stigation, in my of	pinion, death occurre	ed at the time, da	ite and place, a	and due to th	e cause(s)
D	To t To t	×	29b. Signature end title of certifier	enler	bre	45	29c. Licenso			d. Date signed		
1	8691		Neme end eddress of person who co	ompleted ceuse of	deeth (Item 23	(Type, Pri	ini)	2185.	/ Went	150.71	10 Mes	12025
	Sta Registr	re.	31. Date filed (Month, Dey, Year)	10. Redis	strer's Signature	y A	nerte	710	11746		4,	, , , ,

			For State Registrar Am	nend Item#9	,10eperINFO	Maryla 3828 2/4	nd / Dep 4/200/ <i>Ce</i>	artment of I rtificate of	Health and Death	Mental Hyg	g. No.	2004	0096
	sicia	n	Phyllis	,	401)					January	Day	2004	12:15p M
	edica mine		4a. Fecility Name ((If not institution, g	ive street and num	ber)		4b. City, Town,	or Location of Dea		1	ounty of Death	12.135
					Chesapeak	e Resi	idence	Linth:	icum		A	nne Arı	undel
Fune: Direct			5. Social Security 1 714–18–8	8101	Sex 7 1 □ M 2 🕱 F	. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr		Year) , 19	9. Birthp Cour 19 Now	elace (State or Foreign etry) CT Hampshire
land		1	Usual Residence of 10a. State	10b. County		10c. C	ity, Town or Lo	ocation				1	0d. Inside City Limits
Mary a-f sh		ğ	MD	Anne Arı	ındel		Arnold						1 ☐ Yes 2 🔀 No
th with the 23a or 28 ist be not		Funeral Director	10e. Street and Nu		uthern Hill 11s Driv		2	10f. Zip Code 21(012	10		n of What Cour	ntry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Improced it filem 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or othar treumatic avent, The Marical Experiment unit be notified as	1		11. Marital Status 1 ☐ Never Mari 3 ☐ Widowed	ried 2∏ Married 4 🔀 Divorced	12. Was Deced Armed Ford 1 Tes 2 If Yes, Give Year or Dat	es? 2. <mark>g</mark> No		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🐼 No	dispanic Origin? (! an, Mexican, Puel Specify:	Specify Yes or No- rto Rican, etc.)		Race - Americ Black, White, Decify: Whi	etc.
nin 72 ho n "natur	100	Completed by		15. Decedent's I	rade completed)		16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retire	pation during most of wo	orking 1	6b. Kind	of Business/Inc	dustry
d with giene er tha		Ę	Elementary/Seco	ondary (0-12)	College (1-	40r 5+)		lerk			West	ern Ele	ectric
nd 2 should be filed within 72 hours af tilth and Mental Hygiane. 27 is marked other than "naturel; or treumatic aven, the Micrel E.	9	o pe	17. Father's Name Walter		t)					me (First, Middle, M beth Colwe	aiden Su		(
d 2 sho th and N 7 is ma			19a. Informant's N Paul Mir		(Type, Print)			ng Address <i>(Street</i> 81 Stonet		ural Route Number,			
s 1 an f Heal item 2		-	20a. Method of Dis			20b.	Place of Dispo	sition (Name of	-	Date 2	_	ion - City or To	D 21146 wn, State
Page:				☐ Cremation 3 5 ☐ Other (Spec	□Removal from St	ale	-	natory or other place ence ceme	Journ	lary 5,		Haven,	
permit. Pages 1 a Department of Hea Importent: If item any injury or otha	once		21. Signature of Fi	peral Service Lice	2h	===	Ba	Name and Address Arranco & 95 Gov. R	ss of Facility				neral Home D 21146
The law requires that the death certificate be executed to the law requires that the attending physician and the burial-transit or one as the burial-transit.	al examiner	Ical Eva	Immediate Cause disease or condition resulting in death) Sequentially list confirmed in a cause of the cause (Disease or that initiated events resulting in death)	onditions, nmediate injury	b	r as a consec r as a consec r as a consec	qu <i>e</i> nce of):	, è . e .	olon .	cancer			Onset and Death
at the death certific by the attending p tached for use as	Physician/Med	ysiciallying	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 9 ☐ Unknown	months?		h 2 ☐ Feta nt at time of c	aldeath 3 □	Ectopic pregnancy Other (specify)	,		23d.	Date of deliver	y Day Year
w requires that been signed b should be deta	2	בר '	Part II. Other signif	ficant conditions	contributing to dea	th but not res	sulting in the ur	nderlying cause giv	en in Part I.	23e. Did toba			e cause of death?
	Completed									24a. Was an autopsy perform	24 2No	4b. Were autop prior to com death? 1 \(\sum Yes \(2 \)	sy findings available pletion of cause of
sician: Th certificate irector, pag	B. C.		25. Was case refer examiner?	,	Hospital:		1556	Oth	0.51	ath (Cheak only one)			
ng Ph fter th ineral	- 15	100	1 ☐ Yes 200 27. Manner of Deat		28a. Date of (Month,		ER/Outpatient 28b. Time of Injury	28c. Injun Worl	4 U Nursing F	lome 5 \(\text{Normal esident} \) 28d. Describe how			
in Line	Certification:		2 Accident 3 Suicide 4 Homicide	6 Could not to	28e. Place of	Injury - At h	ome, farm, stre	eet, factory, office		28f. Location (Stre City or Town,	et and Nu State)	umber or Rural	Route Number,
na Hospital 24 hours a na Funaral I	Medical		29a. Certifier (Check only one)	Certifying P	hysician: To the basi miner: On the basi and manne	s or examina	owledge, death ation and/or inv	occurred at the tin estigation, in my of	ne, date and place pinion, death occu	, and due to the cau irred at the time, date	se(s) and and plac	manner as sta	ted. the cause(s)
To tha within 2 To tha complet	Me		29b. Signature and	title of certifier	1	M	10	29c. License	e number	290	. Date sig	gned (Month, D	ay, Year)
		;	30. Name and addr	ess of preson of	1 /00	of death (Item	n 28a) (Type (F	Print) \(\Lambda\)	2 (8	1	1.	2104	
	State		31. Date filed (Mon	th. Day, Year)	004 32 Aeg	istrar's Signa	ature Se	y Me	VI-(3)	Unnapa	10	الآار	2140

			1 - For State Registrar	State of Marylan	d / Depa	artmen <i>rtificat</i>	t of H e of L	ealth a Death	ınd M		giene leg. No.	2001	. 00964
		3	1. Decedent's Name (First, Middle, Last)							2. Date of Dea Month	th Day	Yea	3. Time of Death
	Physici /Medic		Harriet Louis	e McDona	1d	,				anuary	2,	2004	4:50 P ^M
	Examir	ner	4a. Facility Name (If not institution, give s					Location of	f Death		1	County of De	
		÷ (0	Cherry Lane Nursin				irel	If Under 2	14 Uen				George's
	Funeral		5. Social Security Number 6. Sex 10	M 2DF	iast <i>birtnday)</i> Yrs.	If Under Months		Hours	Min.	8. Date of Birth (Month, Day	, Year)		irthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	xx. 88			i			Nov 30	, 19	15 V1	rginia
	yland		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation		_					10d. Inside City Limits
	a-f s	ctor	Maryland Prince G	eorge's Up	per Ma	r1bor	0						1 ☐ Yes 2 ☐ No
	iff the	Director	10e. Street and Number			10f. Zip					10g. Citi	zen of What (Country?
	hours after death with the Maryland tural; or Items 23e or 28e-f show at Examiner: ust be nutified at		87 Watkins Park Dr)774					S. A.	
	er de	Funeral	11. Marital Status 1 Never Married 2 Married	Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Deced If Yes, spec	dent of Hi cify Cubai	spanic Orig n, Mexican,	gin? (Spe , Puerto f	cify Yes or No- Rican, etc.)		14. Hace - An Black, Wh	nerican Indian, hite, etc.
5	irs aft	by F	3 Widowed 4 Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		1 ☐ Yes	2 X) No	Specity:				Specify: W	hite
5	2 hou	ted	15. Decedent's Educ			dent's Usua			-4		16b. Ki	nd of Busines	s/Industry
7	within 72 ene. than "na!	ple	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	life.	kind of wo DO NOT u	rk done d se retired,	uring most	or workir	ig			
7	filed wi Hygien other th	Completed	12		F	Iomema	ker					n Home	
_	0 = 0 >	Be	17. Father's Name (First, Middle, Last)	1			ĺ			(First, Middle,		Sumame)	
2	nould be I Mental narked o	2	0	breath	10h Madi		/64			theride		. T Cana	7:- C- d-)
<u> </u>	es 1 and 2 should bot Health and Ments fitem 27 is marked ir other traumatic e		19a. Informant's Name/Relationship (Ty) Gerald McDonald /	•	1	•	,			Upper 1			,
	1 and Heali em 2		20a. Method of Disposition	20b. F	lace of Dispo	sition (Nan	ne of	Ţ		ate			or Town, State
2	Pages nent of int: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 3 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	emetery, crei ington			1	/14/	2004	۸ - 1 - 1	neton	Virginia
saltimore,			21. Signature of Funeral Service License										eral Home
ñ	Departit Departit Import any inj once.		& P. Finil	7						l, Bowie			
ni L	rate be executed Wedical Whysician and The burial-transit The	dical Examiner	23a. Part 1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Se wentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e cause on each line. COROHAR Due to (or as a conseq	ART(uence of): uence of):						-		Approximate Interval Between Onset and Death MANY イモル
.O. DOX 00	The law requires that the death certificate be executed the has been signed by the attending physician and sage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	I death 3	⊒Ectopic pr □ Other (sp					2	3d. Date of d Month	elivery Day Year
λ, T	res that igned b		Part II. Other significant conditions con	-	-		ause give	n in Part I.		23e. Did to	bacco u		to the cause of death?
	w require been signature	ompleted by	HYPERTENSION	1, DEM	EM 11	H				1 🗆 Y	es 2[]No 3∏F	Probably 4
Vital Records,	e lawr has be ye 2 sh	ble								24a. Was a autop	Sy	24b. Were a	autopsy findings available completion of cause of
		S								perfor 1 ☐ Yes		death?	s 2ENo
VII.	ician Sertific ector	Be	25. Was case referred to medical examiner?	ospital:			Othe	APT.		(Check only or			
Ö	Phys this al dir	2	1 Yes 2 No	1 Unpatient 2 U	ER/Outpatier 28b. Time o		/A	4 E INUI		ne 5 Reside			ecify)
0	ding h. h. After funer	to Fo	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury	м	8c. Injury Work	? ′es 2 □ N			ov injur		
DIVISION OF	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, str	reet, factory	/, office		2	8f. Location (S City or Town			Rural Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical ((Check only one)	ician. To the best of my knower: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred vestigation	at the thin in my op	e, date and inion, deat	Julaou, a h occurre	nd dea to the e d at the time, d	auez(s) late and	and manner t place, and du	to stated. ue to the cause(s)
	To the Hos within 24 h To the Fun completely	Me	29b. Signature and title of certifier	, ,	<u>.</u>	290	. License	number		2	9d. Date	signed (Mor	nth, Day, Year)
	->-0		1 HONE	op mi			02	318	31		1	03-	2004
			30. Name and address of person who co	mpleted cause of death (Item	23a) (Type,	Print)	A.V	E++	T-1	. LAU	RE	L M	D20707
			R.G.BHOJRAJ 31. Date filed (Month, Day, Year)	32 Registrar's Signa		רנ תו	L.l. A	U -++	, ,	gam d		(*	
	Sta Regist	ate rar	JAN 0 5 200		& De	and I							

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of	Marylar				ealth a Death	and Me	ental Hyg	iene g. No.	200	+ 009	65
	Physici	20	1. Decedent's Name (First, Middle, La	st)						1	2. Date of Deat Month	h Day	Year	3. Time of Dea	
de S	Physici /Medic		Mary		Ruth	-		O'Ne			JANUARY	7	2004		7 M
	Examin	er	4a. Facility Name (If not institution, giv		ber)		,		Location of	of Death			County of Dea		
			MEMORIAL HOSPITAL 5. Social Security Number 6. S		. Age (In yrs.	last hirthday)		BERLA 1 Year	AND If Under 2	24 Hrs. 8	R Date of Birth		ALLEGAN		reian
	Funeral Director			_ м эД г	86	Yrs.	Months	Days	Hours		B. Date of Birth (Month, Day, 10 / 01 / 1			thplace <i>(State or Fo</i> bu <i>ntry)</i> y land	roigir
			Usual Residence of Decedent								10/01/1	. / 1 /	IIai		
	nylan ihow		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Li	
	Ba-f a	cto		egany		Cumber								1 X Yes 2 □	7140
	with th		10e. Street and Number				10f. Zip		F 0 0		1		en of What Co	ountry?	
	s 23s	ra	229 Baltimore Av	12. Was Dece	tent Ever in 11	19 12 1	Nas Daca		502	nin2 (Snac	ify Vas or No-	US.	A 4. Race - Ame	nican Indian	
36	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23e or 28e-f ahow any figury or other traumatic event, the Medical Examination must be notified at ODGe.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed For 1 Tes Il Yes, Give Year or Da	ces? 2 (XINo				n, Mexican, Specify:	, Puerto R	ify Yes or No- ican, etc.)	1	Black, Whit		
21215-0036	2 hou	ed	15. Decedent's E	ducation		16a. Deced	lent's Usu	al Occupa	ation			16b. Kin	d of Business		
215	nin 72 In 'n	Completed	(Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-	4or 5+)	(Give	kind of wa DO NOT u	rk done d se retired	turing most	of working	7				
N	giene giene grithe	E O	8	Joinego (1		Cu	stod	ian				E	ducatio	n	
p	al Hygie d other	Be	17. Father's Name (First, Middle, Last)					18. Mother	r's Name (First, Middle, N	faiden S	Sumame)		
yla	should be fand Mental I marked of numatic eve	၉	Milburn	Geo	rge		ittl			lian			Gree		
Jar	2 sh and lam raum	1	19a. Informant's Name/Relationship (1					Route Number	•			
e,	of Health ar		James F. O'Neal	/ son	20b. F	Place of Dispo	NATIONAL PROPERTY.	Account to the last termination of the	Id Ave	enue,	Cumberl		ation - City or	21502 Town State	_
ية	if its		1)∑ Burial 2 ☐ Cremation 3 ☐		1 /	cemetery, cren	natory or c	ther plac							
Baltimore, Maryland	rtant rtant		*4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lices		Pro	osperit	y IJM	C. Cet	n . (01/07	/2004	F1	intstor	Home, P.	A .
Ba	Depa Depa Impo any t		PIXA	7.1.	1						Cumber			21502	А.
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on ea	ich line.		er the mod						,	Approximate Interval Between Onset and Deati SUDDEN	n h
8760,	The law requires that the death certificate be executed and let has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to animediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (c	or as a consequence as	(denice of):									
.O. Box 6	at the death certific by the attending p tached for use as I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 ☐ Feta int at time of c	aldeath 3□	Ectopic pi Other (sp					23	3d. Date of del Month	ivery Day Year	
rds, P	quires that n signed b uld be deta	þ	Part II. Other significant conditions of MYOCARDIAL INFARC	_	ath but not res	sulting in the ur	nderlying o	ause give	en in Part I.		23e. Did tob	1	/	the cause of death	
Records,	The law requir te has been si age 2 should	Completed	HYPERTENSION								24a. Was ar autops perford 1 Yes 2		24b. Were au prior to death? 1 \(\sum \) Yes	topsy findings avail completion of cause 22 No	able of
<u>ra</u>	rtifice dor. p	Be C	25. Was case referred to medical		•				26. Place	of Death (Check only on	-1-		37	
)	nysic nis ce direc	Tof	examiner? 1 ☐ Yes 2 ◯ No	Hospital: 1XIn	patient 2	ER/Outpatien	3 DC	Oth Oth	er: 4 ☐ Nur	rsing Home	e 5 ☐ Reside	nce 6	Other (Spec	sify)	
o uo	Attanding Physician: The Ir death. ector: After this certificete haby the funeral director: page		27. Wher of Death 1 Natural 5 ☐ Pending 2 ☐ ccident investigatio		finjury , Day Year)	28b. Time of Injury	M 2	8c. Injury Work	rat t? Yes 2 □ N		ld. Describe ho	w injury	occurred		
Division of Vital	o the C	Certification:	3 Suicide 6 Could not be determined	288. Place	ol Injury - At h g, etc. (Specil	ome, larm, stro fy)	et, factor	y, office		28	f. Location (Sti City or Town		Number or Ru	ırai Route Number,	
	To the Hospital within 24 hours a To the Funeral I completely filled	edical (29a. Certifier (Check only one) 1 Certifying Pt 2 Medical Example (Check only one)	nysician: To the l miner: On the ba and mann	sis of examina	owledge, death ation and/or inv	occurred	at the tim , in my op	e, date and pinion, deat	d place, an	d due to the ca I at the time, da	use(s) a te and p	and manner as place, and due	stated. to the cause(s)	
	To the To the Comp	ž	29b. Signature and title of certifiar	11	7		290	c. License	number		29	d. Date	signed (Monti	h, Day, Year)	
)	1/2		1 Trong	Klan-	200	a 1 :		D005	54004			1/	4/9	4	
-	F		30. Name and address of person who												
_	nes		DR. SHIV KHANNA,				HWAY	, LAV	ALE,	MD	21502				
	Sta Registi		31. Date filed (Month, Day, Year) JAN 0.5 2004		gistrar's Signa	ature 4	loc	1.							

		For State Registrar			nd / Depa	artment of H	ealth a		Hygie Reg.		04	00	966
		1. Decedent's Name (First, Middle	, Last)					2. Date of Month		Day Y	ear	3. Time of	Death
Physicia /Medic		Tillie OBUSEK						Jan.	4,	2004	Jai	200	AM
Examin		4a. Facility Name (If not institution	, give street and n	umber)		4b. City, Town, or	Location of	Death		4c. County of	Death		
		St. Catherine'	s Nursin	g Center	7		sburg			Frede			
Funeral Director		5. Social Security Number 176-14-5714 Usual Residence of Decedent	6. Sex 1 ☐ M 2 🛣 F	7. Age (In yrs. 92	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date of (Month, Oct.				ace (State o y) nsy1va	
and and		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					10	d. Inside Ci	ty Limits
Mary -f sh	ţ	Maryland Was	hington		Ma	ugansvill	Le					1 🗌 Yes	2 🛚 No
r 28e	rec	10e. Street and Number				10f. Zip Code			10g.	Citizen of Wha	t Count	ry?	
h with	ie D	13715 Village	Mill Dri	ve		21	L767			USA			
peritinities of the property of the control of the peritine of	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marri 3 ※ Widowed 4 □ Divorced	Armed	s 2∭No Give	- 1	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 ऄ No	spanic Origi n, Mexican, Specify:	in? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Black, ' Specify:	White, e		
2 hou	pe	15. Decedent	's Education		16a. Dece	dent's Usual Occupa	ition		165	. Kind of Busin	ess/Indu	ustry	
hin 7.	Completed	(Specify only highes Elementary/Secondary (0-12)	7	(1-4or 5+)	_	kind of work done of DO NDT use retired,	uring most ()	of working					
d with	Ю	12	0		c1	.erk				retai1	. sa.	les	
be file be file d oth	Be	17. Father's Name (First, Middle, Constantine 01						s Name <i>(First, Mid</i> .e1a Waszo					
y IC	ဥ	19a. Informant's Name/Relations			10h Mailir	ng Address (Street a					to Zin (adol .	
d 2 st d 2 st th and th and treur		Jane Blash - n			1	Autumn I							
Heali Heali tem 2		20a. Method of Disposition		20b. F		sition (Name of matory or other place		Date		Location - Cit			
ages ant of tt: If if		1 ⊠Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S				natory or other place Cemetery		/7/04	Po	ort Vue	. Pa		
orten		21. Signature of Euperal Service		~ ~	$\overline{}$	Name and Addres					_		
B T D D D D D D D D D D D D D D D D D D		1 Jan XI	- 	Kersen		415 E.Wil	son B					1740	
Physician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions	only one cause or a.	causea the death each line.	van	er the most of dying	1	ardiac or respirator				Approximate Interval Bets Onset and C	eath
icate be executed physician and site burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	o (or as a consec									J
DIVISION OF VILLA NECOLUS, T.O. BOX 05 To the Hospitel or Attending Physicien: The law requires that the death certifica within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	outcome of pregnate birth 2 Feta gnant at time of controls of the control of the controls of the controls of the control of the	aldéath 3 [Ectopic pregnancy Other (specify)			_	23d. Date o Month			Ye ar
w requires that it been signed by should be deta	þ	Part II. Other significant condition	ons contributing to	death but not res	sulting in the u	nderlying cause give	en in Part I.		id tobace	2 No 3		cause of d	
The law re the has bee	Completed	0,0						p	has an utopsy enformed as 2 🖸	? dea	r to com th?	sy findings a pletion of ca	available ause of
Cien: 1 icien: 1 sertifical ector, p	Be (25. Was case referred to medical examiner?						of Death (Check or	lly one)			1	
Phyeic Phyeic this ce	2	1 ☐ Yes 2 No			ER/Outpatier		4 A Nurs	sing Home 5 🗆 R			Specify)		
ling PI		27. Manner of Death 1 XNatural 5 □ Pendin	9	te of Injury onth, Day Year)	28b. Time of Injury	Work	rat 4 ⊲? Yes 2.⊟N		be how i	njury occurred			
Attending at death. ector: Afte by the fune	Certification:	2 Accident investig 3 Suicide 6 Could determ	not be 28e. Pla	ce of Injury - At h	ome, farm, str	eet, factory, office	103 2 0 10	28f. Locatio		and Number	r Rural .	Route Num	ber,
Itel or rs afte el Dire	Cert	4 Homicide	bui	Iding, etc. (Speci	ry) 			City of	Town, S				
To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check only 2 Medical one)	Examiner: On the and ma			n occurred at the tim vestigation, in my op	oinion, death		ne, date	and place, and	due to t	he cause(s)
with com	Σ	29b. Signature and title of fertifie	la	ual	lm	29c. License	1870	os	29d.	Date signed (A	Onth, D	ay, Year)	
5H		30 Name and address of person	IMD	310	S. Set	on Ave,	E	imm its	bu	ra Ma	1	21	727
Sta Registr		31. Date filed (Month, Day, Year)	6 2004	Registrar's Sign	S. A	serle							

			1 - For State Registrar	State of M	laryland / Dep	oartmen e <i>rtificat</i>	t of H e of L	ealth a Death	ind Me	ntal Hyg	giene Reg. No	2001	00967
	Physici	an	1. Decedent's Name (First, Middle, Las							. Date of Dea Month	Da	y Year	3. Time of Death
1	/Medi		John		enneth	-	Pu			JANUARY		2004	2102 M
8	Examir	ıer	4a. Facility Name (If not institution, give MEMORIAL HOSPITA))		FOWN, or					County of Deat LEGANY	n
	Funeral Director		5. Social Security Number 6. Social Security Number 1	9X 7. A.	ge (In yrs. last birthda 64 Yrs.	y) If Under Months	1 Year Days	If Under 2 Hours	Min.	Date of Birtl (Month, Day 3 / 1 5 / 1	y, Year)	9. Birt Co Ariz	hplace (State or Foreign untry) Ona
	P.		Usual Residence of Decedent		140.00.7								
	anylar show	-	10a. State 10b. County		10c. City, Town or								10d. Inside City Limits 1 ☐ Yes ② No
	28a-1	ectc	WV Mine 10e. Street and Number	ral	Ric	lgeley 10f. Zip	Code				10a Cit	izen of What Co	
	with Se or	٥	Route 3 Box 232	(Pattors	on Crook F		2675	5.2				USA	,
	death	Jera	11. Marital Status	12. Was Deceden					in? (Speci	fy Yes or No- can, etc.)		14. Race - Ame	
9	or ite	Ē	1 ☐ Never Married 2]X Married	Armed Forces 1 ☐ Yes 2 ☒ If Yes, Give	No	1 ☐ Yes			, Puerto Hi	can, etc.)		Black, White Specify:	e, etc.
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23e or 28e-1 show other traumatic event, the Medical Examiner mast be mullified at	Completed by Funeral Director	3 Widowed 4 Divorced	Year or Dates:									White
15-(n 72 h "natu	lete	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Dec	edent's Usua ve kind of wor . DO NOT us	al Occupa rk done d se retired	ation Ju <i>ring</i> mos <i>t</i>	of working	,	16b. K	ind of Business/	Industry
12	within iene. then	mc	Elementary/Secondary (0-12) 1 2	College (1-4or	5+)	et Met					Ма	nufactu	rina
	illed Hygi other	Be C	17. Father's Name (First, Middle, Last)		, one		La I			First, Middle,			LINE
lan	should be and Mental I marked o	To B	G.K.	Pugh				Jesse	2	J	ewe1	L1 F	ranklin
Maryland	and N		19a. Informant's Name/Relationship (7	ype, Print)		•	,				-	or Town, State, Z	lip Code)
	and and and and and and and and and and		Jettie E. Pugh /	wife				232, I		ley, W		26753	
Baltimore,	T of H If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State		ematory or o	ther plac	1	Dat		20c. Lo	ocation - City or	Town, State
Ħ	t. Partmen		'4 □Donation 5 □ Other (Specify		Cumber 1a							berland	
Bal	permit. Pages 1 and Department of Heali Important: If Item 2 any Injury or other 2000.		21. Signature of Fuperal Service Licen	Elsons								and, MD	1 Hone, P.A 21502
	Physician /Medical		23a. Part1. Enter the disease, or com, shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	a. Vent	od the death. Do not e ricular Fi s a consequence of):				cardiac or i	espiratory ari	rest,		Approximate Interval Between Onset and Death 20 minutes
,	cate be executed by physicien and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infliated events resulting in death) Last	Due to (or a	ardial Inf s a consequence of): s a consequence of):	arctio	on						30 minutes
P.O. Box 68760,	death certif e attending id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death	B ⊟Ectopic pr B ⊟ Other (sp						23d. Date of deli Month	very Day Year
	requires that the een signed by th rould be detache	by PI	Part II. Other significant conditions of	ontributing to death	but not resulting in the	underlying c	ause give	en in Part I.		23e. Did to	bacco u	use contribute to	the cause of death?
rds	en sig	edt	<u>Metastatic Carci</u>	noma- sma	ll intesti	ne				1 U Y	es 2	□ No 3 □ Pro	obably 4 DUnknown
Records,	The law re ite has be vage 2 sho	Completed								24a. Was a autop perfor 1 XI Yes	sy med?	prior to death?	topsy findings available completion of cause of
ita	ian: intifica ctor, p	Be C	25. Was case referred to medical examiner?					26. Place	of Death (Check only or	ne)		
Ž V	hysic his ce Il dire	7	1 ☐ Yes 2X No	Hospital: 1 Inpat	· · · · · · · · · · · · · · · · · · ·			4 🗀 1901				6 □Other (Spec	city)
o u o	ding P. After t funera	tlon:	27. Manner of Death 1XX Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inj (Month, D	ay Year) 28b. Time	of 2	8c. Injun Work	rat ⟨? Yes 2.∐.N		d. Describe h	ow injur	y occurred	
Division of Vital	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Ir	njury - At home, farm, atc. (Specify)					f. Location (S City or Tow			ral Route Number,
	ne Hospit 24 hours se Funere letely fille	edical C	29a. Certifier 1 💢 Certifying Ph (Check only 2 Medical Examone)	ysician: To the bes niner: On the basis and manner s	t of my knowledge, de of examination and/or stated.	ath occurred investigation	at the tim	ne, date and pinion, deat	d place, and	d due to the d at the time, d	ause(s)	and manner as d place, and due	stated. to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier	1		290	. License	number		2	29d. Dat	te signed (Month	n, Day, Year)
	11/		Willem	tan	m MA		D254	106			Jan	uary 5,	2004
	16 1 .		30. Name and address of person who										
	11 10		William D. Lam 31. Date filed (Month, Day, Year)		47 Virgi trar's Signature	nia Av	renue	e, Cum	berla	and, MI) 2	1502	
	Sta Regist	ate rar	JAN 0 5 200	8.	eres A	Apa	che	/					

DHMH 17 Rev 1/2001

			1 - For Stete Registrar	State	of Maryla		artment rtificate			and Me	-	iene 0 0 4	00968
			Decedent's Name (First, Middle)	, Last)		-				2	. Date of Deat		3. Time of Death
	Physici	an	Phyllis		roctor					T:	Month anuary	5,2004 Yeer	7:45 A M
	/Medic		4a. Facility Name (If not institution				4b. City. 1	Fown, or	Location o		arrace 1	4c. County of Deatl	
	Examin	er	Charles County	_		r	LaP					Charles	
			5. Social Security Number	6. Sex		s. last birthday)	If Under		If Under 2		Date of Birth (Month, Day,		nplace (State or Foreign
	Funeral Director		219-72-4682	1□M 2 ▼F	44	Yrs.	Months	Days	Hours	Min.	(Month, Day, iay 11,	Year) Con	vland
			Usual Residence of Decedent										
	yland		10a. State 10b. County		10c. 0	City, Town or Lo	ocation						10d. Inside City Limits
	Mar Mar	ţ	Maryland Charle	es	Lá	aPlata							1 Yes 2 □ No
	r 28	Director	10e. Street and Number				10f. Zip	Code			11	og. Citizen of What Co	untry?
	h wit	<u> </u>	306 E Hawthorne	Dr			206	546				USA	
	deat	Funeral	11. Marital Status		cedent Ever in	U.S. 13.		ent of His	spanic Orig	gin? (Specif	fy Yes or No-	14. Race - Amer Black, White	
9	after or Ita	F	1 ☐ Never Married 2 ☐ Marr	ed 1 Tes	2 7 No		1 ☐ Yes 2		Specify:	, 1 0010 111	ouri, oto.,	Specify: B]	
င္တ	e e e	Completed by	3 Widowed 4 Divorced	Year or			10 163 2	- - - - - - - - - - -	ороспу.			Specify. B1	ack
5-0	72 h natu	etec	15. Decedent (Specify only highes		d)	16a. Dece (Give	dent's Usua kind of wor DO NOT us	l Occupa k done di	tion uring most	t of working		16b. Kind of Business/I	ndustry
2	e unithin	id L	Elementary/Secondary (0-12)	-T-	(1-4or 5+)	1		e retired)				Domestic	
7	be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "naturel", or itams 23a or 28e-f show event, the Medical Exertance rust be molified at		12	(нопе	maker		10 Matha	de Name //	Cinch Adiabath A		
밀	ba fill H d ott	Be	17. Father's Name (First, Middle,	Edelen	Sr				Ruth		_	Maiden Surname)	hineton
<u>₹</u>	should nd Man marke imaric	ဥ	Joseph		SI						A		shington
Maryland 21215-0036	2 sh and is m		19a. Informant's Name/Relations		Brother		-					City or Town, State, Z	
	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artment of Health and Marial Hygiene. ortant: If item 27 is marked other than "naturel; or Items 23a or 28e-1 show injury or other traumatic event, the Madical Exurating rutal be radified at injury or other traumatic event, the Madical Exurating rutal be radified at .	1 3	Joseph William 20a. Method of Disposition	raeren c		Place of Dispo				Dat		20c. Location - City or	
Baltimore,	ges 1 t of H if ite		1 Burial 2 Cremation	3 □Removal from	n State	cemetery, cre	matory or ot	her place					
<u>=</u>	permit. Pages Department of t Important: If ite any injury or of		'4 □Donation 5 □ Other (S	-	Re	esurrec			-		4	Clinton,Mar	ryland
39	permit Depar Impor Impor once.		21. Signature of Funeral Service	Licensee			2. Name and			•	_	_	_
_	00 = e d		23a. Part1. Enter the disease, or	Mar.					_			asco,Maryl	and Approximate
,160,	Ate burial-transit	cal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due t	O (or as a conse	equence of):	hitia <u>l</u>	/	ung	Đi;	sease		Onset and Death
.O. Box 68	death certific e attending p id for use as t	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	outcome of preg b birth 2 Fe gnant at time of known	tal death 3	⊒Ectopic pre □ Other (spe					23d. Date of delif Month	very Day Year
Vital Records, P	es De de	ρ	Part II Other significent condition ASTHMA	ons contributing to	death but not re	esulting in the u	inderlying ca	ause give	n in Part I.		23e. Did tob 1 ☐ Ye	acco use contribute to s 2 ☑ No 3 ☐ Pro	the cause of death?
ខ្ល	w requir bean s should	Completed	Dinhetes	mellit	2.1						24a. Was ar	24b. Were au	topsy findings available ompletion of cause of
Re	Tha lav	щć	e ja oci «	111(1111)							autops	ned? death?	_/
ā			25. Was case referred to medical						OC Place	of Dooth //	1. 	□No 1 Yes	22 No
₹		o Be	examiner?	Hospital:	Inpatient 2	☐ ER/Outpatie	at 3C DO	Otho	r		Check only one	nce 6 □Other (Spec	
o	ding h. After fune	tion: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pendin 2 ☐ Accident investig	28a. Dai (Mo	e of Injury onth, Day Year)	28b. Time of Injury		Bc. Injury Work		28		w injury occurred	uy)
Division	in Diffe	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 288. Pla	ce of Injury - At Iding, etc. (Spe	home, farm, st	reet, factory,	, office		28	f. Location (Str City or Town	reet and Number or Ru , State)	ral Route Number,
	To the Hospitel or Al within 24 hours after of To the Funeral Dirac completely filled in by	ledical (29a. Certifier 1 Certifylr (Check only 2 Medical one)	Exeminer: On the	he best of my k basis of exami anner stated.	nowledge, deat nation and/or in	th occurred a evestigation,	at the time in my op	e, date and inion, deat	d place, and th occurred	d due to the ca at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and litle of certifie	, //				. License	_		29	d. Date signed (Month	, Day, Year)
			Inul	//ara	6/		Δ	005	809	95		1/07/04	
(0 =		30. Name and address of person	who completed ca	use of teath (It	ет 23а) (Туре,					/1 7	211	
	365		11345 Jem	prooke	H3,5	Ste /	104,	Was	dort	4, N	DY	0605	
	Sta Registi		31. Date filed (Month, Day, Year) JAN 0	7 2004	Redistrar's Sig	nature /	Sparke						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 4 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3 Time of Death Month Day **Physician** 1:05 pm ΩĬ 02 2004 Charles Arnold Renn, Jr. /Medical 4e Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner 34119 Somerset Road Pocomoke City Somerset If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 8/13/1938 5. Social Security Number 7. Age (In vrs. lest birthdev) Birthplace (State or Foreign Country) **Funeral** Hours 12 M 2□ F Months Davs Director 65 Washington, 224-48-6472 Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural, or Items 23s or 28s-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits T is merked other than "natural", or flems 23s or 28s-f show traumetic evant, the Medical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director Pocomoke City MD Somerset 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 34119 Somerset Road 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritel Status Black, White, etc. 1 2XYes 2 Ne 60 If Yes, Give Year or Dates: 963 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Completed by 3℃ Widowed 4 □ Divorced white 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Government Engineer 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ellen Godfrey Charles Arnold Renn, Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Edward McFord (uncle) 30569 Depot St., New Church, VA 23415 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ②Cremation 3 ☐ Removal from State ö 1/3/04 Salisbury, MD 4 ☐ Donetion 5 ☐ Other (Specify) Salisbury Crematory injury 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Holloway Melson Funeral Home, P.A. CFSP 103 Linden Ave., Pocomoke City, MD 21851 Jano 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner ed by the attending physician and detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No þ within 24 hours after death.

To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be o 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Be Completed 1 ☐ Yes 2 ☐ No 1 Yas 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 4 Nursing Home 5 X Residence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29a. Certifier 29b. Signeture and title 29d. Date signed (Month, Dev. Year) who completed cause of death (Item 23e) (Type, Print) S. AUSBURY 2801 15+ 08-W 145 31. Date filed (Month, Dey, Year) 32. Refistrar's Signeture State

DHMH 16 Rev 6/95

Registrar

JAN 0 6 2004

State of Maryland / Department of Health and Mental Hygiene? 00970 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year EVELYN MABEL FARRAND REEBER 875 A M /Medical 04 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Berlin Worcester 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 ☐ M 2 🗶 94 152-36-3026 Director 3/30/1909 Iowa Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Mudical Examiner must be notified at Director Yes 2 □ No Camden Atco 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a 114 Hayes Mill RD USA Funeral 08004 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced "natural", 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withi nent of Health and Mental Hygiene. ant: If item 27 Ia marked other than Professor Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Almond Farrand Mabel Dickman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 828 East of the Sun Fenwick Island, DE Lyn McCool 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1/7/04 permit. Pages 'Department of H Important: If ite 1 ☐ Burial 2 Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Cape Henlopen Crematory Frankford, DE 22. Name and Address of Facility he Burbage Funeral Home 21. Signature of Funeral Service Licensee 25a. Part1. Enter the disease, or complied shock, or heart failure. List only one 108 William St. Berlin, MD death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or conditio resulting in death) Welmonio /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to initial cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sicien and burial-transit Due to (or as a consequence of) Physician/Medical attending p Box (IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months' Day Year 4 Pregnant at time of death 5 Other (specify) o 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Vital 1 ☐ Yes 2 ☐ No 1 Yes 2 1 Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 ☑ 1√0 1 Ampatient 2 ER/Outpatient 3□ DOA ō 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Medical Certification; 28d. Describe how injury occurred Division 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide n 24 hours after de ne Funeral Directo bletely filled in by ti 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 ho
To the Fune
completely f (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person y ho completed cause of death (Item 23a) (Type, Print) Berle 9733 Hellmung Done 31. Date filed (Month, Day, Year) Registrar's Signature State JAN 0 7 2004 Registrar

12004

9

Da

EVELYN Accber 152-36-3026

		1 - For State Registrar	State of Ma	rylan						7111	4 00971
		Decedent's Name (First, Middle, Last) Roberta	Ellen S	SHANK					Month	Day You	3. Time of Death
		Washington County				Hage	rstown	of Death		4c. County of De	
Funeral Director		213-40-4726		(In yrs. I	ast birthday) 60 Yrs.			Min.	B. Date of Birth (Month, Day, August	9. 8 30,1943	irthplace (Stete or Foreign Country) Maryland
Maryland f ahow Ilied at	tor	10a. State 10b. County	n								10d. Inside City Limits 12□Yes 2□No
th with the 23a or 286	To produce of the company of the c	•									
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28e-f ahow sumaite event, the Medical Evanning must be notified at	d by Funer	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🖾 No						ecify Yes or No- Rican, etc.)	Black, Wh	nite, etc.
within 72 h iene. Than "netu	omplete	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 54	+)	(Give life. L	kind of work do DO NOT use ret	ne during mo tired)	est of worki	ng		No. 2 1 1 3. Time of Death 6:50 Am 4c. County of Deeth Washington ar) 9. Birthplace (Stete or Foreign County) 1943 Maryland 10d. Inside City Limits 1287es 2 No Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: White Kind of Business/Industry redit card Co. 16 Sumame) 10 Davis 17 Year 18 Year 19 Since State, Zip Code) 19 Approximate 19 Interval Between 19 Onset and 21740 Approximate 19 Interval Between 10 Onset and Death 2 WK. 23d. Date of delivery 10 Maryland 21740 Approximate 10 Interval Between 10 Onset and Death 2 WK. 24b. Were autopsy findings available 10 year of Completion of Cause of death? 10 Yes 2 No 24b. Were autopsy findings available 10 year of Completion of Cause of death? 11 Yes 2 No 24b. Were autopsy findings available 17 Yes 2 No 25 No 3 Probably 4 Unknown 26 Other (Specify) 1 Yes 2 No 27 No 28 Office Specify) 1 Yes 2 No 29 No 4 Other (Specify) 1 Yes 2 No
uld be filed Mental Hyg riked other	Be		use				18. Moth	ner's Name		10d. Inside City Limits CENS'es 2□No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry credit card Co. Middle, Maiden Sumame) Try C. Davis Number, City or Town, State, Zip Code) Prstown, Maryland 21740 20c. Location - City or Town, Stete Hagerstown, Maryland 21740 10ry arrest, Approximate Interval Between Onset and Death 2 WK. AMERICAN BURNOW 23d. Date of delivery Month Day Year Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?	
and 2 sho ealth and N m 27 ia ma		Calvin Shank, Jr.			551 F	rederio	ck Str	eet,	Hagersto	wn, Maryl	and 21740
t. Pages 1 rtment of H rtant; If ite		1 XBurial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify)		Ce	se Hil	natory or other p	ery	Janua 6, 2	2004 I	Hagerstown	n, Maryland
permi Depa Impo		Poleut B. O	Ponker	, the death	41	5 East	Wilson	B1vd	l., Hagen	rstown, Ma	aryland 21740
Physician /Medical Examiner		shock, or heart failure. List only one Immediate Cause (Final disease or condition	Due to (or as a	consequ	PAILU	ih E					Interval Between Onset and Death
ate be executed thysician and the burial-transit		that intilated events C.	Due to (or as a	consequ	ence of):		210 (7)	2	CAN	*-E/-	0. W.O.
attending p	hysiclan/Medl	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 2 4 ☐ Pregnant at ti	Fetal	death 3 🗌						
quires that en signed I	by	Disk X as ill.	li fus	not resu	4.1		1				
	Complet	Au per lipidea	uia'						autopsy perform	ed? prior to death?	completion of cause of
Physicien this certifical al director.	Be	examiner?	1 Minpatien			30 004	Other: 4 🗆 N	ursing Hon	ne 5 Residen	ice 6 □Other (Spi	ecify)
o the Hospital or Attending Physicien: within 24 hours after death of the Funeral Briector: After this certifical completely filled in by the funeral director.	rtification	†}≦Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injur	y - At hor	Injury	M 1	Vork?]No	8f. Location (Stre	eet and Number or F	lural Route Number,
Hospitel c 24 hours at Funeral D stely filled in		(Check only 2 Medical Examine	or: On the basis of e	xamınatı	vledge, death on and/or inv	occurred at the estigation, in my	time, date a y opinion, de	nd place, a ath occurre	nd due to the cau	isa(e) and manner a	s stated. e to the cause(s)
To the within To the comple		29b. Signature and title of certifier	0	J		DZ	3819			1-3-0	4
o'H'		30. Name and address of person who com Wary E. Money		ath (Item	23a) (Type, F Will	Print) / Stren	et. 1	Yage			10d. Inside City Limits DENYes 2 □ No Country? Inerican Indian, hite, etc. Phite Selindustry and Co. Interval Between Interval Between Onset and Death Denyer When Probably 4 □ Unknown autopsy findings available of completion of cause of earth? Probably 4 □ Unknown autopsy findings available of completion of cause of earth? Probably 4 □ Unknown autopsy findings available of completion of cause of earth? Probably 4 □ Unknown autopsy findings available of earth? Probably 4 □ Unknown autopsy findings available of earth? Probably 4 □ Unknown autopsy findings available of earth? Probably 4 □ Unknown autopsy findings available of earth? Probably 4 □ Unknown autopsy findings available of earth? Probably 4 □ Unknown autopsy findings available of earth? Probably 4 □ Unknown autopsy findings available of earth? Probably 4 □ Unknown autopsy findings available of earth? Probably 4 □ Unknown autopsy findings available of earth? Probably 4 □ Unknown autopsy findings available of earth? Probably 4 □ Unknown autopsy findings available of earth? Probably 4 □ Unknown autopsy findings available of earth? Probably 4 □ Unknown autopsy findings available of earth? Probably 4 □ Unknown autopsy findings available of earth? Probably 4 □ Unknown autopsy findings available of earth? Probably 4 □ Unknown autopsy findings available of earth? Probably 4 □ Unknown
Sta		31. Date filed (Month, Day, Year) AN 0.5 2U	32. Registrar	's Signatu	O. Sp	rede					

			1 - For State Registrar	State of I	Marylar		artmen rtificat			and M	lental Hyg	giene Reg. No.	004	009	72
	Obveisi		1. Decedent's Name (First, Middle, L	.ast)							2. Date of Dea Month		Yeer	3. Time of D	eath
	Physici /Medio		EDWINA GR	ACE SEAF	RL						1	4	2004	0839	М
7	Examir	er	4a. Fecility Name (If not institution, g				1		Location of	of Death			ounty of Death		
			Atlantic Gener		_	4 -44:44 4 1		erlir		24 Hrs			Vorceste		
М	Funeral Director		5. Social Security Number 6. 139-14-8123	Sex 7. 1 □ M 2 X 0 F	Age (in yrs. 81	last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Birth (Month, Day 12 / 20 /	(. Year)	9. Birthp Cour	lece (State or I	Foreign
			Usual Residence of Decedent		01						12/20/	1922		NJ	
	yland		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						1	0d. Inside City	Limits
	a-f-e	ctor	MD Worce	ester		Ocean	Pines							1 X Yes 2	!□No
	or 28	Director	10e. Street and Number				10f. Zip	Code				•	n of What Cour	try?	
	ath w 8 238	rai	4 Leigh Dr.			-		2181					SA		
	er de Items	une	11. Marital Status 1 □ Never Mamed 2 Married	12. Was Decede Armed Force 1 Tes 2	s?	l.S. 13.	Was Deced	lent of History of Cubar	spanic Orig n, Mexican	gin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)	14.	. Race - Americ Black, White,		
36	irs aft	by Funerai	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date			1 ☐ Yes :	No X	Specify:			S	ресіту: Wh	ite	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. vitier then "naturel", or Items 23a or 28e-f ehow wit, the Medical Examiner must be notified at		15. Decedent's	Education			dent's Usua					16b. Kind	of Business/Inc	lustry	
215	hin 7.	ple	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4)	or 5+)	(Give	kind of woi DO NOT us	rk done d se retired)	uring most	t of worki	ng				
2	giene giene er th	Completed	12			Но	mema	ker				Ow	n Home		
p	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Las	•							(First, Middle,		ımame)		
yla	ould Men Marke	2	Eulo D. Ba								Springe				
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23a or 28a-1 show apprintury or other traumatic event, the Medical Examiner must be notified at ance.		19a. Informant's Name/Relationship								I Route Numbe			Code)	
	1 and Health em 2 ther 1		Dianne Hollin 20a. Method of Disposition	gsnead	20b. F	Place of Dispo		_	r. Uc		Pines,		21811 tion - City or To	um State	
Baltimore,	nt of I		1 ☐ Burial 2 XCremation 3		te _ c	cemetery, cren	natory or o	ther place		/6/0)Д		kford,		
亞	artme artant ortant injury		' 4 ☐ Donation 5 ☐ Other (Spec		Cap	oe Hen									
Ba	Depa Impo any i		V Fred	Bude			INR W	illian	Th	ie B	urbage din, ME	Fune	eral Hor 811	ne	
	***		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that out	sed the deat									Approximate Interval Betwe	
	Physician		Immediate Cause (Final disease or condition		200	0 A-1	0 = 0	Ω	c	00				Onset and De	
	/Medical		resulting in death)	a. Due to (or	as a conseq	uence of):	7	61	YCC	D.K.					
Н	Examiner		Sequentially list conditions	b. Sep	Sis										
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	11.	as a conseq	Trees.									
	and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		na as a conseq	TTM	100								_
8760,	icate be executed physicien and s the burial-transit	ai E		D.	u a	ti 500									
687	The law requires that the death certificate be executed tte has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	dicai		d. 10110	aa	3111)								
	that the death certific ed by the attending p detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor	ne of pregna		X2.				157	23d	I. Date of delive	D.	
Box	death a atter	ciar	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant			Ectopic pro Other <i>(sp</i> e					200	Month	Day Yea	ar
P.O.	t the c by the achec	hys	9 Unknown	9□ Unknown	1										
	es tha igned I be det	by P	Part II. Other significant conditions	contributing to death	but not res	ulting in the ur	nderlying ca	use give	n in Part I.		23e. Did to	oacco use	contribute to th	e cause of dea	th?
ğ	w require been sig should b										1 🗆 Ye	es 2 🗆 N	lo 3 🗆 Prob	abiy 4 Unk	cnown
000	e law re has be je 2 sho	Completed									24a. Was a		4b. Were autop	sy findings ava	ailable
ď		Com									perforr		death?	2□ No	30 01
ita	ysician: The is certificate hadirector, page	Be (25. Was case referred to medical examiner?						26. Place	of Death	Check only on				
× ×	Physic this ca	10	1 Yes 2 No	Hospital: 10 Inpa		ER/Outpatien			4 LI NUI	rsing Hor	ne 5□Reside	ence 6	Other (Specify)	
ū	tending Ph Jeath. Tor: After th the funeral	on:	27. Manner of Death 1 Natural 5 Pending	28a. Date of In (Month, I	njury Da <i>y Year)</i>	28b. Time of Injury		Bc. Injury Work			28d. Describe ho	w injury o	ccurred		
sio.	Attending Physician: r death. sctor: After this certifics by the funeral director, I	cati	2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not	he			М		es 2 🗆 N						
Division of Vital Records,	f or Attendate after death	Certification;	4 ☐ Homicide determine	d 286. Place of	etc. (Specify	ome, tarm, stre	eet, factory,	office		*	28f. Location (St City or Town		umber or Rura	Route Number	ζ,
	Hospitel		29a. Certifier 1. Certifying F	hysician: To the be	st of my kno	włedge, death	occurred s	at the time	a, date and	d place a	and due to the co	ause/s) an	d manner as at	ated	
	F 24 F 8	edicai	(Check only 2 Medical Execute)	eminer: On the basis and manner	ot examina	tion and/or inv	estigation,	in my opi	inion, deat	h occurre	ed at the time, di	ate and pla	ice, and due to	the cause(s)	
	To the within 2 To the complet	M	29b. Signature and title of certifier	1			29c.	License	number		2	9d. Date s	igned (Month, L	Day, Year)	
•			Meller	H			OC	060	553	5	17	anu	any 4,	2004	
71/	_		30. Name and address of person you				Print)						7		
ンズ	5		Nadia Angov 31. Date filed (Month, Day, Year)				y Dr	. Be	rlin,	MD	21811				
	Sta Registr	_	IAN 0 5		strar's Signa	H. Co	Ball P								

DHMH 17 Rev 1/2001

12-20-1922-1/4/04

Searl, Edwine G. 139-14-8123

_		Physic /Med		1 - For Stete RegistreAMEND ITEM #25 1. Decedent's Name (First, Middle, Las THON	State of Maryla PER PHY G829 3, 0 MAS H. SAVAGI	/03/04 ८ ₽	rtificate of	Death		g. No.	
		Exami		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Deat	h	4c. County of D	gath
		- Francis		PENINSULA REGIONA 5. Social Security Number 6. Se		CCN FOV	If Under 1 Year	50/15641			
		Funeral Director			ΩM 2□F 80		Months Days			Year) 23	Sifthplace (State or Foreign Country) VA
		land ow		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation		·		10d Inside City Limits
		the Marylan 288-f show	tor	VA Accomad	ck	Atlanti	С				1 ☐ Yes 2 ☒ No
		vith the	Funeral Director	10e. Street and Number 10381 Atlantic Rd.			10f. Zip Code	02	10		Country?
		ns 23e	era	11. Marital Status		1 U.S. 13.	233		necity Ves or No-		merican Indian
	920	urs after o	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	i	if Yes, specify Cut 1 ☐ Yes 2 No	Hispanic Origin? (S pan, Mexican, Puerl Specify:	o Rican, etc.)	Black, W	hite, etc. Black
\	Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. "natural", or Items 23a or 28a-f show if item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Madical Experient near constitution.	Completed by	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation le completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retire	pation during most of wor ad)	king	6b. Kind of Busine	ss/Industry
B	21	e filed with at Hygiene. other ther	Con	4		Se1	f-Employ			Salvage	Accomac, VA Accomac, VA Accomac, VA Accomac, VA Accomac, VA Accomac, VA Accomac, VA Accomac, VA Accomac, VA Accomac, VA Accomac, VA Approximate Interval Between Onset and Death On
Junes Strage	and	ould be fil Mental H arked otl	To Be	17. Father's Name (First, Middle, Last) Eddie Savage					ne <i>(First, Middle, Ma</i> S Harmon	aiden Sumame)	
3	ary	2 should be and Menta Is marked aumatic ev	F	19a. Informant's Name/Relationship (7)		19b. Mailir	g Address (Street	t and Number or Ru	ral Route Number, (City or Town, State	, Zīp Code)
63		of Health item 27 I		Ann N. Wharton, Da		Р.	0. Box 2	46, Tempe	rancevill	e, VA 23	442
F	Baltimore,	Pages hent of Hint: If its		20a. Method of Disposition 1 Burial 2 Cremation 3 1 4 Donation 5 Other (Special)			sition (Name of natory or other pla				
	altir	permit. Pages Department of Important: If i any injury or once.		21 Signature of Funeral Servic 4 in en			Name and Addre	etery 01/ ess of Facility	10/04	Atlantic	, VA
	8	89 1 8	Ú.	muy 1.	Olan h.	Co	oper & H	lumbles Fu	neral Co.	, Accoma	c, VA
40				23a. Part 1. Enter the disease for composhock, or heart failure. List only o		eath. Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory arres	t,	Interval Between
	1	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Sepsis Due to or as a cons	equence of):					1
	B	Examiner	L	Sequentially list conditions.	cerbero	Jasoub	« Acei	dent (st	roke)		3 Wee Ks
		ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons				,		2
	o,	execu an and rial-tra		that initiated events resulting in death) Last	Due to (or as a cons		λ				J Weeks
	68760,	flicate be ex physician as the burial	edical		Dehyd	rotion					Bwacks
2	.O. Box	Attending Physician: The law requires that the death certificate be executed refath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant b. Was decedent pregnant c. 1 □ Yes 2 □ No c. 9 □ Unknown	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other <i>(specify)</i>	у			,
C	s, P	uires that signed t d be det	by Pi	Part II. Other significent conditions cor		esulting in the un	derlying cause giv	en in Part I.	23e. Did tobac	co use contribute	to the cause of death?
C	ord	w requires been signi should be	eted	Acute Renal	failure				1 🗆 Yes	2 □ No 3 🗹 🖡	robably 4 Unknown
3	Rec	ne law has b ge 2 s	mple	Aremia	11				24a. Was an autopsy performed	24b. Were a	utopsy findings available completion of cause of
	tal	ysician: The is certificate hadirector, page	0	Cardio myo p	atry.			26 Place of Deca	1 ☐ Yes 2 ☑		
	Ž	Physici this cer al direct	To B	examiner?	lospital: 1 Inpatient 2	☐ ER/Outpatient	3 DOA Oth		h <i>(Check only</i> one) me 5 ☐ Residenc	e 6 □Other (Sp.	ecify)
	Division of Vital Records,	anding Ph ath. or: After th	atlon:	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor M 1		28d. Describe how		33.77)
1	Divis	To the Hospital or Attending F within 24 hours atter death. To the Funeral Director: Atter completely filled in by the funer.	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre	et, factory, office		28f. Location (Stree City or Town, S	t and Number or F State)	lural Route Number,
11		To the Hospital or within 24 hours after To the Funeral Dirth completely filled in I	Medical	29a. Certifier (Check only one) 1 V Certifying Phys 2 Medical Examin	sician: To the best of my kr ner: On the basis of examin and manner stated.	nowledge, death nation and/or inv	occurred at the tinestigation, in my o	ne, date and place, pinion, death occur	and due to the caus ed at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
		To the within To the comp	Me	29b. Signature and title of certifier	0. O. M.	0	29c. Licens	and the second second			
				0.173 1030 00	111			066071	5	Jan/1	12004
(7.	H.3		30. Name and address of person who co		əm 23a) (Type, F ७ ୮႑ / M.∜					
		Sta Registr		31. Date filed (Month, Day, Year) JAN G 5 2	32. Registrar's Sign		Caroll 6				

ORIGINAL

				1 For State				land / De	partme		lealth and N	Mental Hygi	ene2 ()		00974
			_	Registrar	- 14					ate or	Death	2. Date of Death	g. No.		3. Time of Death
		Physici /Medic		Decedent's Name (First, Middle Gary	e, Last)	Dav	<i>y</i> id	Smith				Month January	Day	Yeer 104	07:25 M
	7	Examir		4a. Facility Name (If not institution	n, give st	treet and nu	mber)		4b. C	ity, Town, o	r Location of Death		4c. County		
-				Southern Maryla	and i	Hospit	tal			Clint	on .		Princ	e Ge	orge's
		Funeral		5. Social Security Number	6. Sex		7. Age (In	yrs. last birthda	y) If Un Mont	der 1 Year hs Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey,			place (State or Foreign intry)
		Director		214-58-0218	XX	M 2□F	52	Yrs.	North	Days	Tiodis iviii.	May 16,1		Cal	ifornia
		<u>p</u>		Usual Residence of Decedent								4			
		anylan show		10a. State 10b. County			100	c. City, Town or							10d. Inside City Limits
M		e Ma	cto	Maryland Charl	es			Waldor	E						1 ☐ Yes ŽŽŽNo
6		1 th	Director	10e. Street and Number					10f.	Zip Code		10	g. Citizen of	What Cou	ntry?
. 1		th wi	a	4113 Bluebird	Dri	ve				206	503		U	S.A	•
9		dea	Funeral	11. Marital Status		2. Was Dec Armed Fo	edent Ever	in U.S.	3. Was De	ecedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-		e - Ameri ck, White,	ican Indian,
_	9	after or Ite	E	1 Never Married 2 ☐ Marr	ried	1 ☐ Yes If Yes, Gi					Specify:	(1110011, 610.)			
1 0	8	ours.	by	3 ☐ Widowed 4 ☐ Divorced		Year or D	ates:		1 🗀 1 0:	s XX No	Specily.		Specif	<i>y</i> :	White
10	5-0036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural" or Items 23a or 28a-1 show adent, the Medical Examinar mast be notified at	Completed	15. Deceden (Specify only higher	t's Educ st grade	ation completed)		16a. De	edent's U	isual Occup work done	ation during most of work	ting 1	6b. Kind of B	usiness/Ir	idustry
- 0 +	21	of thin	Jqr.	Elementary/Secondary (0-12)	Ť	College (1-4or 5+)	life	. DO NO	T use retired	d)				
8	21	ygiel ygiel ner ti			1 1	2		Sta	tisti	cal A					vernment
00	Ē	tal H d of	Be	17. Father's Name (First, Middle,	Last)							e (First, Middle, M		ne)	
	Yla	ould Mer warks	2	Bernard Smi							Alice	Mile			
	Maryland	d 2 should be filed within th and Mental Hygiene. 7 is marked other than traumatic avent, the M		19a. Informant's Name/Relations					_		and Number or Run				
		es 1 and 2 of Health if item 27 or other tr		Rebecca Turne	r (S	ister		41. 0b. Place of Dis			d Drive W	-			
7	Baltimore,	Pages 1		20a. Method of Disposition 1 XX urial 2 ☐ Cremation	3 □Re	moval from	State	cemetery, c	rematory	or other plac	0011		Oc. Location	•	
Y	Ë	Pa men tant:		`4 □Donation 5 □Other (S	pecify)		1				Cemetery				
0	Sall	permit. Pages Department of Important: If is any injury or o		21. Signature of Funeral Service	License	ө					ss of Facility $L\in$			-	
1	ш	20 E = 9		Monis of . Au	ant		0257							into	n, MD 20735
0	ж			23a. Part1. Enter the disease, or shock, or heart failure. List	complic	ations that o	aused the each line.	death. Do not e	enter the n	node of dyin	ng, such as cardiac	or respiratory arres	st,		Approximate Interval Between
		Physician		Immediate Cause (Final disease or condition		C		ISEMI							Onset and Death
5		/Medical		resulting in death)	(a.	Due to		nsequence of):	-/ \				-		
S.		Examiner		Cognisation list conditions	h	V	ROS	EPS1	5						
-		D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	"			isequence of):	A						
Ö		cuter	Examiner	that initiated events	c.	Y	NEU	MONI	r						
(3)	0	ite be executed ysician and ne burial-transit		resulting in death) Last		Due to	(or as a cor	nsequence of):							
	3760,	requires that the death certificate be executed seen signed by the attending physician and hould be detached for use as the burial-transit	icai		d.										
-	89	death certificate I attending physi of for use as the t	Physician/Medi	IF FEMALE:									-		
y	Вох	th ce tendi	an/l	23b. Was decedent pregnant	23	ßc. If yes, ou 1 □Live b			B Ectopia	c pregnancy	,			te of deliv	*
2	O. E	dea he at	Sici	in the past 12 months? 1 □ Yes 2 □ No		4∐Pregr 9⊡Unkn	nant at time	of death	Other	(specify)			MO	nth	Day Year
Supine	P.0	that the de led by the a detached t	h.	9 Unknown				····					_%		
7		es tha igned be del	by	Part II. Other significant condition				t resulting in the	undertyin	ig cause giv	en in Part I.				he cause of death?
0	ecords,	w requir	ted	CEREBRAL	1	ALSY			-			1 Yes	2 🗆 No	3 Prot	bably 4 Sunknown
	S	aw s b	ple									24a. Was an autopsy	24b.	Were auto	ppsy findings available impletion of cause of
5	OT	The ate he	Completed									performs	ed?	death?	
Ban	Vital	Physician: The this certificate har director, page	Be (25. Was case referred to medica examiner?	1						26. Place of Deat	h (Check only one)			
0	-		Tol	1 ☐ Yes 2 ☑ Mo	Ho	ospital:	patient	2 ER/Outpat	ent 3	DOA Oth	er: 4 Nursing Ho	me 5 Residen	ce 6 □Oth	er (Specif	<i>y)</i>
3	n of	ding Ph J. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pendir		28a. Date (Mon	of Injury th, Day Yes	28b. Time		28c. Injur Wor	y at k?	28d. Describe how	injury occur	red	
~	Ö	tendir leath. tor: A	atic	2 Accident investi	gation				М		Yes 2 □ No				
1	Division	or Attencation death Director: In by the	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		28e. Place build	of Injury -	At home, farm, pecify)	street, fac	tory, office		28f. Location (Stre City or Town,		er or Rura	il Route Number,
并江西	0	itel or urs afte rel Dir lled in		W.											
1		Hospitel 4 hours a Funerel ely filled	edicai	(Check only 2 Medical	ng Physi Examin	er: On the b	asis of exai	/ knowledge, de mination and/or	ath occurr investigat	red at the tin	ne, date and place, pinion, death occur	and due to the cau	se(s) and ma	inner as s	tated. the cause(s)
(1)		To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.	Med	one) 29b. Signature and title of pertifie		and man	ner stated.	~		29c. Licensi			1. Date signe		
		2 ₹ 6 S		255. Signature and title or pertille	(PHY	SICIA	m)	1	D 53	_	290			d 2004
	,				1						21,		040	2	- 200 T
		NR 11		30. Name and address of persha		npleted caus	se of death	(Item 23a) (Typ	e, Print)	- 44	101, 7	=7. W1	+811.A	P 7-	56/
		Sta	to	31. Date filed (Month, Day, Yeer)		-		- (VILL	-11	101	1001	JONIN	010	701
		Registr		JAN 0		004	Malus	Signature	Good	W					

DHMH 17 Rev 1/2001

		•	For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of He			ene 200	00975
		75	1. Decedent's Name (First, Middle, Last,	i				2. Date of Death Month	Day Year	3. Time of Death
10	Physicia /Medic		Betty	Jane		Valen	tine	JANUARY	1 2004	13:20 M
	Examin		4e. Fecility Name (If not institution, give	street and number)		4b. City, Town, or I	Location of Death		4c. County of Dee	th
ī.			MEMORIAL HOSPITAL			CUMBERLAN			ALLEGA	
	Funeral		Social Security Number 6. Security Number	7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) C	thplece (State or Foreign ountry)
	Director		212-24-2115	JM ZLAF	7.5 Yrs.			04/23/19		ryland
	pur *		Usuel Residence of Decedent 10a, State 10b, County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	eho eho	2	WV Minera	1	Ridge	lev				1 X Yes 2 □ No
	the N	Director	10e, Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
	with a or		P.O. Box 15 (Ced	dar Avanua)	26753			USA	
	hours after death with the Maryland turel', or Iteme 23e or 28e-f ehow at Essmirant must be radiiled at	Funerai	11. Marital Status	12. Was Decedent E	ver in U.S. 13.	Was Decedent of His	panic Origin? (Sr	pecify Yes or No-	14. Race - Am	
	Iter d	ᆵ	1 ☐ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔀 N	0	If Yes, specify Cuban		Rican, etc.)	Black, Whi	te, etc.
21215-0036	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 No	Specity:		Specify:	White
Þ	72 ho	ted	15. Decedent's Edu (Specify only highest grad		16a. Dece	dent's Usual Occupat	tion uring most of wort	kina 1	6b. Kind of Business	/industry
7	thin 7	npie	Elementary/Secondary (0-12)	College (1-4or 5-	F)	kind of work done du DO NOT use retired)				
2	ed wi	Completed	11		Ho	omemaker	40. 14-4-4-1-1	(5)	Homemal	ker
Maryland	should be filed within 72 hours after death with the Marylan and Mental Hygiene. E marked other than "naturel", or lieme 23s or 28s-f show umatic event, the Medical Examinar must be rediffed at	Be	17. Father's Name (First, Middle, Last)				_	ne (First, Middle, Mi		
S	Men Men Merke Marke	2	William	Kenneth		chell	Teresa	and Charles Alicenters	Scott	Tin Codel
Jar	2 sh and is rr	1	19a. Informant's Name/Relationship (T)			ng Address (Street at				
	ss 1 and 2 should of Health and Me litem 27 is mark r other traumation		Harold D. Valentin	le/ nusban	20b. Place of Dispo	Box 15, R			Tg1111 20 0c. Location - City or	5753 Town, Stete
ğ	Pages nent of H ant: if Its	11 7	1XXBurial 2 ☐ Cremation 3 ☐ F		cemetery, cre	matory or other place				
Baltimore,	ritmer riant njury		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funding Service Licens		Access to the second se	sant UMC C	the state of the s	PROPERTY AND ADDRESS OF THE PARTY AND ADDRESS		Home, P.A.
Ba	permit Page Department of Important: if any injury of once.		21. Signature of the Action of	illam					erland, Mi	•
			23a. Part1. Enter the disease, or comp	lications that ceused	the death. Do not en					Approximate
			shock, or heart failure. List only o							Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. ACUTE RE	SPIRATORY consequence of):	DISTRESS	SYNDROME			DAYS
В	Examiner			b. PNEUMONI						DAYS
		Je.	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		consequence of):					
	cuted nd ransii	Examiner	that initiated events	c						
Ö,	ate be executed sysicien and he burial-transit		resulting in death) Last	Due to (or as a	consequence of):					
8760	certificate be executed ding physicien and use as the burial-transit	lical		d						
ý X	ertifica ling pl	Physician/Med	IF FEMALE:	23c. If yes, outcome of	of pregnancy				201 Date of de	the same
Box	death certifi e attending i ed for use as	ian/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t	2 ☐ Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of de Month	Day Year
Ö	0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	anie or death 30					
م.	res thet figned by	'Ph	Part II. Other significant conditions co	ntributing to death bu	it not resulting in the u	inderlying cause give	n in Part I.	23e. Did toba	acco use contribute t	o the cause of death?
Records,	The law requires thet the tother the bas been signed by the bage 2 should be detache	d by	CEREBROVASCULAR AC	CIDENT				1 ☐ Yes	2 □ No 3 □ P	robably 4 Unknown
Ö	w require been si should t	Completed						24a. Was an	24b. Were a	utopsy findings available completion of cause of
Re	: The law cate has I	Ę						autopsy	ed death?	~
		C	25. Was case referred to medical				26. Place of Dea	th (Check only one	No 1 Yes	3(Z/No
5	ysician: is certifica director,	To B	evaminer? . /	Hospital:	nt 2 ER/Outpatie	Other	-		nce 6 Other (Spe	ocify)
ō	a Phy er this		27. Marher of Death	28a. Date Injury (Month, Day	v 28b. Time o			28d. Describe how		
<u>0</u>	nding Path. r: After e funera	atlo	Natural 5 Pending investigation	(North, Day	nijary		es 2 No			
Division of Vital	or Attending Physician: Ifter death. Director: After this certification by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju	ry - At home, farm, st . (Specify)	reet, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
ō	rs aft	Cer								
	Hospital 4 hours a Funeral I	cai		sician: To the best of iner: On the basis of	examination and/or in					
	To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	one) 29b. Signature and title of certifier	and manner star		29c. License			d. Date signed (Mon.	
		-	290. Signature and time of certifier	TH						
	2		SIM	Dhan	NO TO THE PORT OF	D005	4004	JA	ANUARY 4,	2004
	nRs		30. Name and address of person who c				ATE MO	21502		
	Sta	te	DR. SHIV KHANNA, 1 31. Date filed (Month, Day, Year)		I LONAL HIC r's Signature			21502		
	Regist		JAN 0 5 2004	1 100	as B	Sparks	,			

Please Type or Print in Biack indelibie ink. Assure Ali Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>004</u> Month JAN **Physician** 3,_ 9:05PM Myrtle Bell Worley /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Neme (If not institution, give street end number) Examiner LAPLATA CHARLES CIVISTA MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (Ster Country)
Jan. 23, 1916 Virginia 6. Sex 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) 5. Social Security Number Months **Funeral** Hours Deys 1□M 2♥F Yrs. 87 Director 220-01-5555 Usuel Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 10b. County 1 ☐ Yes X ☐ No Directo Maryland Charles Pomfret 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 9298 Rollingwood Drive 20675 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Deceden! of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Maryland 21215-0020 Specify ð 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Nurses Aide Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jasper William Sparks Rosa Bell Utz 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Audrey M. Schmitz - Daughter 9298 Rollingwood Drive, Pomfret, MD 20675 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Peges 1
Depertment of Hi
Important: If iten
any injury or oth 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 1-6-04 Brentwood, MD Ft. Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Name an Address of Excilly Huntt Funeral Home 21. Signature of Funeral Sergio Licensee M00053 P. O. Box 156, Waldorf, MD 20604 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Phenonia Examiner ettending physician end I for use es the buriel-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieled events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of 28c. Injury at Work? or Attending P ster death. 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 ☐ Homicide To the Hospital c within 24 hours of To the Funerel D completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29a. Certifier Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier D-33426 1-5-04 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) JR., MD PO BOX 2665 LAPLATA, MD 20646 LARRY JENKINS

DHMH 16 Rev 6/95

State

Registrar

31. Dete filed (Month, Day, Year)

JAN 0 5 2004

BELL

32. Degistrer's Signature

			For State	State of I					7111	4 00977
				ast)				2. Date of De	ath	3. Time of Death
	_		Albert Oliver W	ahler						14 0503 AM
after.		_			er)	4b. City, Town	, or Location o		- 1	Death
	LAGIIIII		Washington Coun	tv Hospita	al	Hagers	town		Washin	aton County
	Funeral			Sex 7.	Age (In yrs. last birth	day) If Under 1 Yea	r If Under	24 Hrs. 8. Date of Bir	th 9.	Birthplace (State or Foreign
	The Section of Department of Page Models (124) Albert Oliver Wahler Albert Oliver Wahl									
	D .				100 City Town	or Location				10d Incide City Limits
	anyla ehov	=		aton	**					1
	188-1	ecto	-						10a Citizen of Wha	
	with t			- 1 - 0						Coomy
	s 23	erai			ant Ever in U.S.			nin? (Specify Yes or No		American Indian,
	iten iner	Fu		Armed Force	es?	If Yes, specify Ci	Jban, Mexican	, Puerto Rican, etc.)	Black, V	
39	al', or	by		If Yes, Give		1 ☐ Yes 2 X N	lo Specify:		Specify:W.	hite
21215-0036	2 hou	ted						t of working	16b. Kind of Busin	ess/Industry
2	an "n	ple			- 1	ife. DO NOT use reti	red)	or working		
21	gien th	P P	6			Machinist	-			Mfg.
p		0	17. Father's Name (First, Middle, Las	st)						
<u>×</u>	Ment Ment arke	2							-	
Maryland	2 6 = 8									
	and ealth m 27		<u></u>	on			Bridge	Committee of the same of the s		
ore	of H			Removal from Sta	cemetery,	crematory or other p				
Ē	Pag ment ant:		`4 Donation 5 Dother (Spec	cify)	Greenia					
Baltimore,	Depart Import any in		21. Signature of Funeral Service Lic	ensee	Zzz					
	n sän	<	23a. Part 1. Enter the disease, or co	mplications that cau	sed the death. Do no	t enter the mode of o	lying, such as	cardiac or respiratory a	rrest,	
	Physician		Immediate Cause (Final	D		VIA				
	/Medical			Due to (or	as a consequence of		[- 1 -		N. a.
	Examiner		Sequestially list conditions	, CO	NGPSJI	VE NEA	t121 1	HOLVICE		1)445-
	D #	ner	if any, leading to immediate cause. Enter Underlying	Due to (or	as a consequence of):				0.00
	nd rans	am	that initiated events	. <i>ITO</i>	14167	4	7			YEMOS
o,	e exe ian a urial-		resulting in death) cast	Due to (or	as a consequence of):				
8760,	ate b hysic the b	lica		d					-	
9	entific ling p	Mec	tF FEMALE:	20- 14						
Вох	ath c	lan/		1 Live birth	n 2 Fetal death					
0.	the a	/sic	1 ☐ Yes 2 ☐ No			5 ☐ Other (specify)				
٥.	hat the			contributing to deat	th but not resulting in t	he underlying cause	given in Part I.	23e. Did t	obacco use contribu	te to the cause of death?
of Vital Records,	signe signe		CHROM	ric Al		•	g		Yes 2□No 3[Probably 4 Unknown
0	requ been houk	etec	DEMAL	TAIC	ALC: EAR					
Sec.	e law has t	ldu	[CUN AP]	71070	MALAC	4		auto	psy prior	e autopsy findings available r to completion of cause of th?
E F						1			2 No 1□	Yes 2□ No
VIII.	ician certifi ector		examiner?	Hospital:			Thor:	District Control of the Control of t		
of	Phys this al dir			i inp		allell 30 DOA	4 140			Specify)
L C	After funer	lol	1 Natural 5 ☐ Pending	(Month,	Day Yeer) Inj				now analy occurred	
isi	death death ctor: / the	Ical	3 Suicide 6 Could not	be 280 Place of	Injury - At home farr				Street and Number of	or Rural Route Number.
Division	or A after Direct in by	ertit	4 Homicide determine	building	, etc. (Specify)	ii, street, ractory, onic	~			r risiai riosto rioritado.
_	spital ours ours neral filled		29a. Certifier 1 Certifying	Physician: To the b	est of my knowledge.	death occurred at the	time, date an	d place, and due to the	causa(s) and manne	er as stated
	24 h	dici	(Check only 2 Medical Ex	aminer: On the basi	is of examination and					
	oth oth omp	Me	29b. Signature and title of certifier	1	1	29c. Lice	ense number		29d. Date signed (A	fonth, Day, Year)
			→ 1/1/1/1/1	a hi	LICACTO	7-11	112	Z043	1-5-	64
	,W		30. Name and address of pe son wh	o ompleted cause	of death (Item 23a) (7	ype, Print)			1 5	7
24	<'U		Du Wanto	11111	Medina	l. Campa	1 RA	L Hor. 1	nd 217	42
4	Sta	ate	31. Date filed (Month, Day, Year)	32. Red	istrar's Signature	1	1-0	- Cary		
	Regist		JAN 0 6	2004	Revos B.	parker				

		A.	1 - For State Registrar 1. Decedent's Name (First, Middle, Last)	State of Maryla		artmen ertificat					Reg. I	20	04	0097	8
100	Physici		Virginia E	,	Walser	-			ì	2. Dete of I			ear	3. Time of Death	vI
٦	/Medic Examir		4a. Facility Name (If not institution, give		warser		Town, or	Location o		Jan.	2,	2004 4c. County of	Death	1:45 A	_
	LXUIIII	161	Bradford Oaks N	ursing Home			nton					Prince		orge's	
	Funeral Director		5. Social Security Number 6. Sec. 217 26 5371	7. Age (In y	rs. last birthday) Yrs.	Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of E Month, I Sept	Inth Yes	1927 N	l. Birthpla Count Mary	ace (State or Foreig Tand	n
	yland Now		10a. State 10b. County	10c.	City, Town or Le	ocation							10	d. Inside City Limits	S
	e-fsh	ctor	Maryland Prince Ge	orge's	Fort	Wash	ingt	on					i.	1 Tes 2 Th)
	or 28	Director	10e. Street and Number			10f. Zip						Citizen of Wha		,	
	eath v		7405 Fawle		116 110	144 5		0744	: 0 (0			United			
36	permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. If Item 27 is marked other than "naturel", or iteme 23a or 28e-f show importent: If Item 27 is marked other the "naturel" or 28e-f show eny injury or other treumatic event, the Wadlest Frantise must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married **X*Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 277No If Yes, Give AA Year or Dates:		If Yes, spec		spanic Orig n, Mexican, Specify:	gin? (Spec , Puerto F	cify Yes or h Rican, etc.)	No-	14. Race - Black, Specify:	White, e		
2-00	72 hou		15. Decedent's Edu	cation	16a. Dece	dent's Usua	d Occupa	ition			16b.	Kind of Busin			
218	ithin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	NOT us	e retired,	uring most	of workin	g					4
121	filed with Hygiene other thai	Cor	9th 17. Father's Name (First, Middle, Last)		Но	usewi	fe	10 14-11-	4. 11-	/F:			Home	e	_
Maryland 21215-0036	2 should be fi and Mental H is marked of eumatic ever	To Be	Thomas Vianell		-				Eva (Corkra	n	an Sumame)			
	1 end 2 sh Health and Iem 27 is n		19a. Informant's Name/Relationship (Ty). Kenneth C. Walser	(Husband)	740	5 Faw.	ley .	Ave,	Fort	Route Num Washi	ber, City .ngt(or Town, Sta	2074	Code) 44:	
Baltimore,	Peges 1 ment of H ant: If Iter ary or oth		20a. Method of Disposition 1 □ Burial 2 \(\text{Disposition} \) 1 □ R		p. Place of Dispo cemetery, crei	osition (Nam matory or of	ne of ther place)	Da	ate	20c.	Location - Cit	y or Tow	m, State	
Him	it. Pe irtmen irtent: njury		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligense	1 4	Lee Crem							inton,			_
Ba	permit. Departm Importer eny inju		Days & Kon	1 mores										6633 01d nd 20735	
	Physician /Medical Examiner	100	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a cons	sequence of):					respiratory		ALE	1	Approximate nterval Between Onset and Death	
8760,	death certificate be executed e attending physicien and of for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inditate devents resulting in death) Last	,											
.O. Box 6	death certil e attending d for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time o 9 Unknown	etal death 3	Ectopic pre Other (spe					Ē	23d. Date of Month		/ lay Year	
rds, P	igne be o	by	Part II. Other significant conditions con	atributing to death but not r	esulting in the u	nderlying ca	use give	n in Part I.						cause of death?	
	The lay ate has page 2	Completed	V							24a. Was auto perf 1 \sum Yes		prior	to comp	y findings available bletion of cause of	
Vita	ilcien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	loop to b					of Death (Check only	-				
	Physical dir	2	1 Yes 2 No	lospital: 1 Inpatient 2 28a. Date of Injury	☐ ER/Outpatien 28b. Time of		and the same of	2 Nurs			_	6 Other (S	Specify)		
Division of	Attending Physicien: r death. sctor: After this certific: by the funeral director, I	Certification:	Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year)	Injury	М		es 2 N	lo			ury occurred			
DIV	To the Hospitel or Attenwithin 24 hours after deating to the Funerel Director: completely filled in by the		4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	icity)					City or To	wn, Stai	re)		Route Number,	
	To the Hospitel or within 24 hours atte To the Funerel Dir completely filled in I	edical	29a. Certifier (Check only one) Wedical Examin	sician: To the best of my k ner: On the basis of exami and manner stated.	nowledge, death nation and/or inv	n occurred a vestigation,	t the time in my opi	o, date and nion, death	place, an	d due to the at the time	cause(s	s) and manne od place, and	r as state due to th	ed. ne cause(s)	
	To To Con	Σ	29b. Signature and title of certifier			29c.	License	number	31		29d. Da	ate signed (M	onth, Da	y, Year)	
			,30- Name and address of parson who con	empleted cause of death (It	tem 22a) (T	Print'		177	4/			1/4/6	4		_
D	35		Takh Quality	32. Resistrar's Sig	Living	ITU,	RA	#/	03 7	17. h	Alh	hypai	m	2014	/
	Sta Registra	-	JAN 0 6 2	2004	Ms 1	Soul!	9								

		1 - For State Registrar	State of Marylar		rtment of H tificate of L			ene g. No. 2004	00979
		1. Pecedent's Name (First, Middle, L	ast)				2. Date of Death		3. Time of Death
Physic /Medic		CAMUEL	Assi	MANT	7	1	JANUAR	Day Year	6:30 M
Examir		4a. Facility Name (If not institution, g			4b. City, Town, or	Location of Deat		4c. County of Death)
		9228 Avan	040× 2140.		PARK	341,2		1 1331-1111	12901
Funeral		Social Security Number 6.	Sex 7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day,	Year) 9. Birth	plece (State or Foreign untry)
Director		Usual Residence of Decedent	88	Yrs.			1101-71	913 120	USYLVAVIA
* =		10a. State 10b. County	10c. C	ity, Town or Loc	ation				10d. Inside City Limits
gene. r than "natural", or iteme 23a or 28a-f ahow the Medical Examiner must be notified at	ō	MORNIAGO BATT	rocke	Rick	2/13				1 ☐ Yes 2 No
28a	Director	10e. Street and Number	101012	1 HILLS	10f. Zip Code		10	g. Citizen of What Cou	untry?
38 0		9218 Avan	vale Rosa)	212	24		11.5.A.	
9	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. W	/as Decedent of Hi Yes, specify Cuba	spanic Origin? (S	pecify Yes or No-	14. Race - Amer Black, White	ican Indian,
		1 Never Married 2 Married	1 Yes 2 No		☐ Yes 2 No	Specify:	10 1110411, 010.7	Specify:	11
Ex	d by	₩idowed 4 Divorced	Year or Dates: \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	III				W	HITE
dica	Completed	15. Decedent's (Specify only highest of		(Give I	ent's Usual Occupa kind of work done o O NOT use retired	during most of wo	rking 1	6b. Kind of Business/I	ndustry
N N	ш	Elementary/Secondary (0-12)	College (1-4or 5+)	C . O	~	000		1. PENAIT	- many
ent, the		17. Father's Name (First, Middle, La.	st)	1200	100112	21 / 20 / 20 / 20	ne (First, Middle, M	aiden Sumame)	PULHUA
9 4	Be	Tr 00000	ABBIO	000		0000	~ ^ ^	1-0000	00-
raumatic	ဥ	19a, Informant's Name/Relationship			Address (Street a	and Number or Bu	ural Route Number	City or Town, State, Z	in Code)
tran		[-log. A A. 576	7	17:17	12000	1000	VEDENA	1. Director	53573
other		20a. Method of Disposition	20b.	Place of Dispos	sition (Name of	200105		oc. Location - City or T	Town, State
= ō		Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	Hemoval from State	cemetery, crem	atory or other place	(a)	- 30,	11:00	Oralano
any injury		21. Signature of Funeral Service Lic	1	22.	Name and Address	s of Facility -	100 00 C	MOINTE	1 (6/2)75/10
Important: I any injury o once.		March Than		5	SUCTA S	SOIT OF	000 P201	KILLE MA	RILAND
		23a. Part1. Enter the disease, or co	mplications that caused the dea	ith. Do not ente	or the mode of dying	g, such as cardia	or respiratory arre		Approximate
		shock, or heart failure. List on Immediate Cause (Final	ly one cause on each line.	Musa	condri	al In	Agratid	n	Interval Between Onset and Death
ician dical		disease or condition resulting in death)	Due to (or as a conse	quence on a	L	VI WV	10001.	- 6	for minu
iner			Porgnar	4 Ho	na Dix	uase,		Y	20 2/20
	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	guence of):					4 - 44
ansit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	phypus	ensio?	γ .				40 yrs
rial-tı		resulting in death) Last	Due to (or as a conse	quence of):					
s the burial-transit	dicai		d						
for use as t	0	IF FEMALE:							
e nse	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet		Ectopic pregnancy			23d. Date of delin	very Day Year
tached fo	sici	1 Yes 2 No	4☐Pregnant at time of a 9☐ Unknown	death 5	Other (specify)	·		IVIO I	Day Tour
etact	Physician/M		s annual transfer death but not an	and the same and	dashina asusa sura	h in Dani i	220 Did tobo	acco use contribute to	the cause of death?
ep eq	by	Part II. Dther significant conditions	Oles Iran Co	Loc I	MMC a	Disca	1		bably 4 Unknown
should	eted	Question is	Yand Tenn	208 (1	woodb	in snac	20		
10 2 s	Completed	some of	will farm		(1 may	24a. Was an autopsy perform	prior to co	opsy findings available ompletion of cause of
, page 2								Z No 1 Yes	2□ No
rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		of DOA Othe		ath (Check only one		
al di	2	1 ☐ Yes 🏂 No 27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatient 28b. Time of	3 DOA	4 Indising r	lome 5% Resider	ce 6 Other (Special	ify)
After	lon	Natural 5 ☐ Pending	(Month, Day Year)	Injury	28c. Injury Work	Yes 2 □ No	Zou. Describe nov	injuly occurred	
completely lilled in by the	Ical	2 Accident investigat 3 Suicide 6 Could not	be 390 Place of Leiung At h	nome, farm, stre			28f. Location (Stre	et and Number or Rui	al Route Number
d in b	Certification:	4 Homicide determine	building, etc. (Speci	ify)	. ,, , 01100		City or Town,		
- Fillec			Physician: To the best of my kn						
letely	Medical		aminer: On the basis of examin and manner stated.						
dwo	Me	29b. Signature and title of certifier	111 11.1		29c. License	number	29	d. Date signed (Month.	Day, Year)
4		> f. C. Nor	her!		D.0	01418	5 2	1/19/0	4
10		30. Name and address of person wh	o completed cause of death (Ite	m 23a) (Type, F	Print)				/
1		DR. PORHAG	CKAHLS	750	1/20 2	RORI	ve Tow	SON MA	RYLAM
St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature				7	
Renist	rar	HAN & V ZUU4	A STANDERS AS	ALL STATES	7				

State of Maryland / Department of Health and Mental Hygiene 004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 9:42 p M 2004 January 12 G. **ADAMS** DOROTHY (Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE CO BALTIMORE AUGSBURG NURSING HOME If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🗓 F Months Director 86 218-12-3895 June 24 1917 MARYLAND Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director RANDALLSTOWN BALTIMORE CO MARYLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6 or Items 23e U.S.A. 21133 3501 TEMPLAR ROAD death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural" or hearth jury or other traum. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BALTO CITY SCHOOLS FOOD SERVICES 12th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be WILLIAM GAITHER MARY SCOTT 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marcus Adams/Son 3501 Templar Rd., Randallstown, Maryland 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN CEMETERY 01-17-04 WOODLAWN, MARYLAND 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 21. Signature of Feneral Service Licenses 1206 W NORTH AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Athe-osd **Physician** renotie resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. the attending physicien Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy ō Month Year Day 5 ☐ Other (specify) detached PO 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4₺ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ၉ 28a. Date of Injury (Month, Day Yeer) After thi 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Medical Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funerel Director: A 2 Accident completely filled in by the I 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospitel 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D37573 January 19,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ma MD Keisterston 7 10011 32 Registrar's Signature 31. Date filed (Maha, Pay 2 ea) 2004 State Registrar 23646

,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		State of Maryland / Dep 1- For Amend and Unpend Item #1,23a,27,28a-f pe			
Physic /Med		Decedent's Name (First, Middle, Last) Samuel Wayne Allen SAMUEL W. ALLEN		2. Date of Death Month JANUARY	Day Year 16, 2004 2:17 P M
Exam		4a. Fecility Name (If not institution, give street and number) 312 OLD RIVERSIDE ROAD	4b. City, Town, or Location of Death BROOKLYN		4c. County of Death ANNE ARUNDEL CO
Funera Directo		5. Social Security Number 220-56-8420 6. Sex 1 M 2 F 53 Yrs.	// If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y Jan. 5,	9. Birthplace (State or Foreign Country) 1951 Mary Land
Maryland f show	tor	Usual Residence of Decedent 10a. State Maryland Anne Arundel 10c. City, Town or	Baltimore		10d. Inside City Limits 1 ☐ Yes 2 🖔 No
h with the	al Director	10e. Street and Number 312 Old Riverside Road	10f. Zip Code 21225	100	g. Citizen of What Country? USA
Ind 21215-0036 be filed within 72 hours after death with the Maryland tall hygiene. Indicate than "natural", or Items 23e or 28e-f show event, the Medical Evarial at matter redilled.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Married Forces?	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 X No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Maryland 21215-0036 at 2 should be filed within 72 hours att the and Mental Hylgiene. 27 Is marked other than "natural", or traumatic event, the Medical Event traumatic event, the Medical Event.	Completed by	(Specify only highest grade completed) (Gir	edent's Usual Occupation re kind of work done during most of work DO NOT use retired) Supervisor	ung	sb. Kind of Business/Industry Warehouse
aryland 2 should be filed nd Mental Hygi marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last) Warner O'Dell Alle	en Ruby	e (First, Middle, Ma Lee Ba:	iley
		Mrs. Paula Allen (Wife) 312	iling Address (Street and Number or Ru 2 Old Riverside Rd	, Baltim	ore, Md. 21225
Baltimore, permit. Pages 1 at Department of Hea Important: if Item any Injury or othe		* 4 □Donation 5 □ Other (Specify)	eran's Cemetery 1	/21/04 Cr	oc. Location - City or Town, State rownsville, Maryland
Departit Departit May In		7	McCully-Polyniak F 237 E. Patapsco Av	e., Balto	o., Md. 21225-1856
Physicia /Medica	1	23a. Part1. Enter the disease, or complications that caused the death. Do not eshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Arcotic Intoxica Due to (or as a consequence of):		or respiratory arres	Interval Between Onset and Death
60, to be executed sician and burial-transit	burial-transit al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter understring Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.			
Box 6 death certific e attending p	Physiclan/Medic		DEctopic pregnancy Other (specify)	15t-7.00	23d. Date of delivery Month Day Year
ds, P. uires that signed b ild be deta	Ď	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to the cause of death?
I Records, P.O The law requires that the ate has been signed by the page 2 should be detache.	Completed			24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death? 12 Yes 2 No
Vita sician: certific irector,	o Be	25. Was case referred to medical examiner? **Types 2 \subseteq No	Other	th (Check only one)	ce 6 XOther (Specify) SCENE
Sion ending eath. or: After the fune	Certification: T	27. Manner of Death 1 Natural 2 Accident 3 Suicide 28a. Date of Injury Founding investigation 1/16/04 28b. Time Founding 1/16/04 28b. Place of Injury 28b. Time Founding 1/16/04 28b. Place of Injury 28b. Time 28a. Date of Injury 28b. Time 28a. Date of Injury 28b. Time 28b. Place of Injury 28b. Time 28b. Place of Injury 28b. Time 28b. Place of Injury 28b. Time 28b. Time 28c. Date of Injury 28b. Time 28c. Date of Injury 28b. Time 28c. Date of Injury 28b. Time 28c. Date of Injury 28b. Time 28c. Date of Injury 28b. Time 28c. Date of Injury 28c.	P M 1 Yes 24 No	28d. Describe how Unknown 28f. Location (Stre	rinjury occurred eet and August Fours Number Road State) 3172 016 Kiver State Road
DIVIS spital or Att ours after d nerel Direct		4 Homicide building, etc. (Specify) Found at residence 29a. Certifier 1 Certifying Physician: To the best of my knowledge, de		Brooklyn Pa	rk, Maryland
To the Hospital of within 24 hours at To the Funerel D completely filled in	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated. 29b. Signature and title of certifier		rred at the time, dat	e and place, and due to the cause(s) d. Date signed (Month, Dey, Year)
		30. Name and address of person who completed cause of death (Item 23a) (Typ	O C M E		ANUARY 17, 2004
			111 Penn Stree	t, Baltim	ore, Maryland 21201
Regi	State strar	JAN 2 0 2004 Send Signature	books		

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Reg. NoZUU4 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Yeer Month Physician 5:20 PM JAN /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) Examiner GOOD SAMARITAN BALTIMORE HOSPITAL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign
 Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🗹 F 28 Yrs. Director 14*a* 1 and 2 should be fited within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir then "naturel", or Itams 23s or 28s-f ehow The Medical Examiner must be notified at 1 Yes 2 No Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 __Yes _ 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1□Yes 250No Baltimore, Maryland 21215-0036 Specify: Specify: / (þ 3 ₩idowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) is marked other 18. Mother's Name (First, Middle, Maiden 17. Father's Name (First, Middle, Last) 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Town, State, Zip Code) of Health a Item 27 is 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite eny injury or ot once. 1 Burial 2 Cremation 3 Removal from State 4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a CONGESTIVE HEART FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** b. ATRIAL FIBRILLATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed HYPERTENSION
Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien SEPSIS Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 🛣 No 1 Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 XInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification; To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier KAFROUNI MICHEL, M.D. 29c. License number 29d. Date signed (Month, Day, Year) JAN H. Kaframi REI 000 17,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHEL KAFROUNI GOED SAHARITAN HOLPITAL 5601 LOCH PAVEN BALTIMORE, MA 21239 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 1 1 4

00983

		•	For State Registrar	State of Mai	•	Certifica Contraction			d Wellall	Reg. N			
	Physicia	an	1. Decedent's Name (First, Middle, Las Rosalie Josephine						2. Date of Month		ay 2004	3. Time of E	
	/Medic	al	4a. Facility Name (If not institution, give			4b. Ci	tv. Town, or	Location of D	Janua _{eath}		c. County of Death	4:15	Рм
	Examin	_	Stella Maris					Valley			Baltimore	3	
	Funeral Director		5. Social Security Number 6. Security Number 212–18–9230	DM 255	(In yrs. last birt		der 1 Year	tf Under 24 l		Birth Day, Yea , 191	9. Births Cour Mary.	place (State or ntry) land	Foreign
pue	3		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	n or Location					1	l0d. Inside City	/ Limits
Maryl	of e bo	tor	Maryland Baltimor	~	Notting	rham						1 🗌 Yes	2× No
h the	r 28a	irec	10e. Street and Number		HOCCIII		Zip Code			10g. (Citizen of What Cour	ntry?	
ith wit	238 c	ral D	4102 Chardel Road				21236				S.A.		
should be filed within 72 hours after death with the Maryland	if Health and Mental Hygiene. Item 27 is marked other then "naturel", or Items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3XXVidowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2X2No If Yes, Give Year or Dates:			cedent of Hi pecify Cuba 2000	spanic Origin: n, Mexican, Pi Specify:	? (Specify Yes or uerto Rican, etc.)	No-	14. Race - Americ Black, White, Specify: Whi	etc.	
72 ho	natur	eted	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a.	Decedent's U (Give kind of	sual Occupa work done o	ation furing most of	working	16b.	Kind of Business/In	dustry	
vithin	hen.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) H(iite. Do NOT Omemake)		0	wn Home		
iled v	Hygie ther t		17. Father's Name (First, Middle, Last)		110	Alicharc		18. Mother's	Name (First, Mid				
94 p	fental rked o	To Be	Walter Borkowski					Josepl	hine Gre	zch			
shou	and M		19a. Informant's Name/Relationship (7		1	•					y or Town, State, Zip		
and 2	ealth m 27 i		Agnes Borkowski (S	Sister)			-	<u>'</u>	Ltimore,		yland 212		
. Pages 1	Department of Health and Mental Hygiene. important: If Item 27 is marked other then ery injury or other traumatic event, Item Magnes.		20a. Method of Disposition 1 XBurial 2 Cremation 3 4 Donation 5 Other (Specify	1)	St. St		ıs Cem	etery .	Jan.19,2	004	Baltimore	,Maryla	and
permit	Depar Impor eny in		21 Signature of Funeral Segrice Licen	ISBB		14(ond Addison	uzdzin Easte	ski Fune rn Avenu	ral e, E	Home, P.A ssex, Mar	yland 2	21221
/	nysician Medical kaminer		23a. Party. Enter the diseese, or comp shock, or heart faiture. List only tmmediate Cause (Final disease or condition resulting in death)	olications that caused to one cause on each line a. END STAC Due to (or as a	GE_DEME	NTIA	node of dying	g, such as car	diac or respirator	y arrest,		Approximate Interval Betw Onset and Do	reen
ificate be executed	atlending physician and for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c. Due to (or as a d.									
The law requires that the death certific	been signed by the attending p should be detached for use as	Physician/Med	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	23c. tf yes, outcome o 1 ∐Live birth 2 4 ∐Pregnant at ti 9 ☐ Unknown	Fetel death	3 ⊟Ectopio 5 ⊡ Other	c pregnancy (specify)			_	23d. Date of delive Month	•	ear
us, r.	n signed by	by	Part II. Other significent conditions of	ontributing to death but	t not resulting in	n the underlyin	g cause give	en in Part I.		id tobacc	o use contribute to to	he cause of de pably 4 X Ur	
		Completed							p	tas an utopsy erformed as 211	death?	ppsy findings ampletion of cal	vailable use of
cisn:	ertific ector,	Be (25. Was case referred to medical examiner?	Hospital:			DOA Othe		Death (Check or				
P P	⊊ - 76	- To	1 ☐ Yes 2 📉 No 27. Manner of Death	1 ☐ Inpatien 28a. Date of Injury		tpatient 3	DUA	4 🗀 Nursii			6 COther (Specificary occurred	y) HOSPI	[CE
ding C	th. After fune	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day		n _f ury M	28c. Injun Work	<br Yes 2 □ No					
To the Hospitel or Attending Physician:	within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined		ry - At home, fa (Specify)	rm, street, fac	tory, office			n (Street Town, St	and Number or Rura ate)	il Route Numb	197,
Hospite	within 24 hours after To the Funeral Discompletely filled in	edical (29a. Certifier Check only one) Certifying Ph	nysician: To the best of niner: On the basis of and manner stat	examination an	e, death occurr d/or investigat	red at the timition, in my of	ne, date and p pinion, death o	lace, and due to occurred at the tir	the cause ne, date a	(s) and manner as s and place, and due to	tated. the cause(s)	
o th	vithin Fo the comple	Μe	29b. Signature and title of certifier				29c. License	e number		29d. l	Date signed (Month,	Day, Year)	
-	7			/1-			D	437	25		1/15/0	4	
1	U		30. Name and address of person who								,		
	V		DR. TARIQ MAHM(31. Date filed (Month, Day, Year)	OOD 2300 D 32. Registra	Signature				IUM, MD	2109	3		
	Sta Registi		JAN 2	0 2004 A	Energy	1. A.	north)						

DHMH 17 Rev 1/2001

4:15 p.m.

JANUARY 14, 2004

ROSALIE BRUSH

			1 - For State Registrar	State	of Maryla		artmer <i>rtifica</i> :				lental Hyg	jiene 2	004	00984
	Physici /Medic		1. Decedent's Name (First, Middle KIM BERLY	4		BRU	10-	CAF	RTER	_	2. Date of Dea Month	Day 18	Year 2004	3. Time of Death
	Examir		4a. Facility Name (If not institution	n, give street and n	umber)		4b. City	Town, or	Location of	of Death		4c. Coun	ty of Death	
			St. Joseph's M				1	Tows					altimo	
	Funeral Director		5. Social Security Number 217–94–9651	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs	. last birthday) Yrs.	Months	r 1 Year Days	If Under Hours	Min.	8. Date of Birth (Month, Day Feb 8,	, Year)	Coun	tace (State or Foreign try) yland
	and		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	ocation						10	Od. Inside City Limits
	Mary f sho	ō	Maryland Balti	more		Phoe	niv							1 ☐ Yes 2 X No
	72 hours after death with the Maryland Insture!, or Items 23s or 28s-f show Insal Examiner must be notified at	Directo	10e. Street and Number	LIIOIC		11100		Code				0g. Citizen o	f What Coun	try?
	h witi	a D	2723 Paper Mill	Road				2113	31			1	JSA	
	dea	Funeral	11. Marital Status		cedent Ever in torces?	J.S. 13.	Was Dece	dent of Hi	spanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)		ace - America	
92	or R	y Fu	1 Never Married 2 Marr	ied 1 ☐ Yes If Yes, G	2 X No ive		1 🗆 Yes		Specify:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, , , ,	Spec		
5-0036	urel',	d by	3 Widowed 4 Divorced	Year or	Dates:				4				Wh	ite
	"nat	Completed	15. Decedent (Specify only highes	rs Education st grade completed)	16a. Dece	dent's Usu kind of wo DO NOT u	al Occupa ork done d ise retired	ition <i>uring</i> mosi	t of work	ng	16b. Kind of	Business/Ind	lustry
2121	filed within Hygiene. ther than "	duc	Elementary/Secondary (0-12)	n/a	(1-4or 5+)		Iomem	_				Own	Home	
2	Hygin other	0	17. Father's Name (First, Middle,	<u> </u>					18. Mothe	r's Name	(First, Middle,			
<u>a</u>	ould be Mental arked o	To B	Philip	Bruno					S	ally		Gnag	gey	
Maryland	2 should be filed within 72 hours atter death with the Marylan and Mental Hygiene. Is marked other than "naturel", or Items 23a or 28a-f show aumatic event, Ite Maxical Examiner main be notified at		19a. Informant's Name/Relations				_				l Route Number		n, State, Zip	Code)
oʻ oʻ	and lealth m 27 har tr		Jeffrey A. Cart	er/Husba							Phoenix		21131	
altimore,	ges to the life of the or other		20a. Method of Disposition 1 Burial 2 □ Cremation		i State	Place of Dispo cemetery, crer)	Jan	22, 2004			
	t. Partmen		'4 □Donation 5 □Other (S)	- A	Du1	aney V			,			Timoni	ium, Ma	aryland
Ra	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic a <u>ance</u> .		NIMIN	OI LU	Xe J)Le	mmon	Fune	ral H	lome	of Dula Timoniu	ney Va m, MD	11ey, 21093	Inc.
ł	Physician		shock, or heart failure. List Immediate Cause (Final)	only one causelon	each lin j e.	_								Approximate Interval Between Onset and Death
1	/Medical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CHRONIC PULM CHORY FIBROSIS WITH Due to (or as a consequence of): NTERSTITIAL PN CUMONITIS Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	S	3 years										
	ted sit	niner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consec	quence of):								0
,60,	be executed sician and burial-transit	Ical Exa	resulting in death) Last	C. Due to	(or as a consec	quence of):								
28	ficate g phys			0										
. Box	at the death certificate by the attending phys tached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 Live	itcome of pregn birth 2 Feti nant at time of d nown	al déath 3 □	Ectopic p Other (sp			_			ate ol deliver	y Day Year
J.	that the		Part II. Other significant condition	ens contributing to	leath but not re-	sulting in the ur	nderlvina a	ause dive	n in Part I		23e. Did tot	acco use cor	ntribute to the	e cause of death?
cords,	iaw requires that the as been signed by th 2 should be detache	ted by										s 2 🗆 No	3 ☐ Proba	
Y Y	The te had age	Completed							-		24a. Was a autops perform	y	prior to com death?	sy findings available ipletion of cause of
VItal	ician: certifica ector, p	Be (25. Was case referred to medical examiner?						26. Place	of Death	(Check only on			
- -	Physician: this certific ral director,	ဥ	1 Yes 2 No	A		ÆR/Outpatien			4 LI Nui	rsing Hor	ne 5□Reside	nce 6 □Ot	her (Specify)	
	Jing After fune	atlon;	27. Manner of Death 1. ■ Natural 5 □ Pending 2 □ Accident investig	9	of Injury oth, Day Year)	28b. Time ol Injury	M	28c. Injury Work' 1 □ Y	at ? es 2 □ N		28d. Describe ho	w injury occu	rred	
DIVISION	i Sire	Certification;	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ined 288. Place	e of Injury - At h ling, etc. (Speci	ome, farm, stre	eet, factor	y, office		2	28f. Location (St. City or Town	reet and Num , State)	ber or Rural	Route Number,
2	To the Hospital within 24 hours a To the Funeral Completely filled	ledical (29a. Certifier 1 Certifyin (Check only one)	g Physician: To th Examinar: On the t and mar	e best of my kno pasis of examina oner stated.	owledge, death ation and/or inv	occurred estigation	at the time , in my opi	e, date and nion, deat	d place, a h occurre	and due to the ca ad at the time, da	use(s) and m ite and place,	anner as sta and due to t	ted. the cause(s)
	To the vithin To the comple	Me	29b. Signature and title of certifier	()		N	290	. License	number			d. Date signe		*
	1		J. Custern	O'Donor	on, M	· D	į	000	763	32	1	Tama	x 17.	2004
			30. Name and address of person v		se of death (Ite	m 23a) (Type,	Print)						1	
_	l		Crosson O'Donova				Ave.	D	ında1	k, M	D 21222			
	Sta Registr		31. Date liled (Month (Pan Year)	0 2004 32.1	Registrar's Signa	ature	Sale.	S. S.						

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	1. Decedent's Name (First, Middle, La	ast)				2, Date of Month	Death Day	/ Year	3. Time of De
	ERNEST J.	BONAPARTE				Janua		, 2004	12:22
by Physician/Medical Examiner To Be Completed by Funeral Director	4a. Facility Name (If not institution, gire			•	r Location of Deat	h	4c.	County of Death	
	Maryland General			Baltimo	ore If Under 24 Hrs	1000	2:45	N/A	
		Sex 7. Age (In yrs.	51 Yrs.	If Under 1 Year Months Days	Hours Min.		Day, Year)	Cou	place (State or Fo ntry) H CAROL]
	10a. State 10b. County	10c. Cit	ty, Town or Loca	ation					10d. Inside City L
ğ	MARYLAND N/A		BALTIM	CRE					1 ∰ Yes 2 [
rec	10e. Street and Number			10f. Zip Code			10g. Citi	izen of What Cou	ntry?
0	2524 McCULLOH S	TREET		2123	L7		U	.S.A.	
ner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	I.S. 13. W	as Decedent of H	lispanic Origin? (S an, Mexican, Puer	Specify Yes or	No-	14. Race - Ameri Black, White	
Fu	1 Never Married 2 X Married	1 ☐ Yes 2XXNo	1	Tes, specify Cub. ☐ Yes 2000				Specify:	
þ	3 Widowed 4 Divorced	Year or Dates:						Вьд	
etec	15. Decedent's E (Specify only highest gi	Education rade completed)	(Give k.	int's Usual Occup ind of work done	during most of wo	rking	16b. K	ind of Business/Ir	ndustry
Jdu	Elementary/Secondary (0-12)	College (1-4or 5+)		O NOT use retire				ONCORDITOR	IT ON
	9th grade	1)	CONST	RUCTION	18. Mother's Na	me /First Mide		ONSTRUCT Sumame)	TON
00	17. Father's Name (First, Middle, Las					E LEE D		Jamamo/	
2	ROBERT BONAPART		405 14 11	Add (0+				Town Ctata 7	n Codol
	19a. Informant's Name/Relationship				and Number or R				
	Robert Bonaparte		2524 Place of Disposi		oh St., I	Baltimo Date		aryland ocation - City or T	
F	20a. Method of Disposition 1 X Burial 2 Cremation 3		cemetery, cremi	atory or other pla	сө)	2616	200. LC	Joanson - Only Of 1	omi, biale
	`4 □Donation 5 □ Other (Spec		WSON GR	OVE BAP	01-2	20-04	DARL	INGTON, S	OUTH CAR
1	21. Signature of Funeral Service Lice	ensee	1 22. VT	Name and Addre LLTAM C	BROWN CO	OMMUNIT	Y FUN	ERAL HOM	E P.A.
	Marker	H. Howel			RTH AVENU				
xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consec							
ical		d		-					
nysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of of 9 ☐ Unknown	al death 3 🗆	Ectopic pregnanc Other (specify) _	y		-	23d. Date of deliv Month	very Day Year
δ	Part II. Other significant conditions	contributing to death but not res	sulting in the un	derlying cause gr	ven in Part I.		id tobacco i	use contribute to	i.u
Completed						24a. W		24b. Were aut	opsy findings avai
E C						. , p∈	itopsy erformed? s 2 □ No	death?	
	25. Was case referred to medical				26. Place of De	7		1 (44) 103	
o Be	examiner?	Hospital:	ER/Outpatient	3 DOA Ot	ner			6 ☐Other (Spec	ifv)
	27. Manner of Death	38a Date of Injury	28b. Time of	28c. Inju	ry at	28d. Descrit			77
JE.	1 □Natural 5 □ Pending	FOUND Day Year)	Injury	Wo	rk?]Yes 2.[X No	UNKNO	JN		
JE.	2 Accident Investigati 3 Suicide 6 Could not 4 Homicide	be 280 Place of Injury - At h		P	-	28f. Locatio City or		nd Number or Rui a)	ral Route Number
JE.		Physicien: To the best of my kn	owledge, death	occurred at the ti estigation, in my	me, date and place opinion, death occ	e, and due to t	he cause(s) and manner as d place, and due	stated. to the cause(s)
Certification; T	29a. Certifier (Check only one) 1 Certifying 8 2 Medical Exit	aminer: On the basis of examination and manner stated.							
JE.	29a. Certifier (Check only one) 1 Certifying F 2XMedical Ext	aminer: On the basis of examina		29c. Licen	se number		29d. Da	te signed (Month	. Day, Year)
edical Certification; T	29b. Signature and title of certifier	aminer: On the basis of examina			se number	•		te signed (Month	

		•	For State Registrar	State of Marylar		artment of H <i>tificate of l</i>			gienez (00987	
	Dhysicis		Decedent's Name (First, Middle, Last))				2. Date of Dea		3. Time of Death	
	Physicia /Medic	al	JULIAN H. I			Ab Ciby Town of	Location of Death	Danu	4c.Coun	ty of Death	
	Examin	er	4e. Fecility Name (If not institution, give UNION MEMORIAL HC				TIMORE		/	N/A	
bir-	Funeral		5. Social Security Number 6. Sec		pill but but	If Under 1 Year Months Days		8. Date of Birth (Month, De)	n /, Year)	Birthptece (State or Foreign Country)	7
	Director		062-32-7390 Usual Residence of Decedent	61	Yrs.			04-29-	42	NY	_
	yland low		10a. State 10b. County		ty, Town or Lo	cation				10d. Inside City Limits	
	e Mar	ctor	MD N/	'A BA	ALTIMOR					1√TYes 2 No	
	with th	Director	10e. Street and Number			10f. Zip Code	• •		-	of What Country?	
	ns 23	Funeral	3632 ELLERSIE AVEN	12. Was Decedent Ever in U	J.S. 13.	212 Was Decedent of Hi f Yes, specify Cuba		pecify Yes or No-		SA ace - American Indian,	
36	permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health end Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f ahow any fujury or other treumatic avant, Ite Maryland Examinar must be motified at Angle.	þ	1 Never Married 212 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:		f Yes, specify Cuba 1 ☐ Yes 2 ☑ No	in, Mexican, Puert	o Ricen, etc.)		lack, White, etc.	
5-0036	72 ho	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Deced	dent's Usual Occup- kind of work done of DO NOT use retired	etion during most of wor	king	16b. Kind of	Business/Industry	
2121	within ane. then	mp	Elementary/Secondary (0-12)	College (1-4or 5+)		er Carrie:			II. (1	DOGE OFFICE	
2	filed Hygie other	Be Co	17. Father's Name (First, Middle, Last)		1		18. Mother's Nan	ne (First, Middle,		POST OFFICE	
<u> lan</u>	Mental Mental arked o	To B	JULIAN BROWN	T			MAR	GERY I	HOLLAND)	
Maryland	2 sho		19a. Informant's Name/Relationship (T) FRANCES E. BROWN			ng Address (Street a				m, State, Zip Code)	
	1 end Healti tem 27		20a. Method of Disposition	20b. I		sition (Name of matory or other place		Date		n - City or Town, State	_
altimore,	Peges nent of int: If it iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State		FOREST	ı	22-2004	OWINGS	MILLS, MD	
Balti	permit. Depertm Imports any Inju		21. Signature of Funeral Service Licens			. Name and Addres		MES A. MO	ORTON 8	SONS F.H., INC	C
27			23a. Part1 Epter the disease, or complishock, or heart failure. List only of	lications that caused the dea	th. Do not ent					Approximate Interval Between	
	Pnysician	4	Immediate Cause (Finat disease or condition resulting in death)	. Endst	UGC	LUI	a Ca	ncer		Onset and D ath	
*	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):		0				
	-	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consec	quence of):						
	acuted ind transil	ami	Cause (Disease or injury that initiated events resulting in death) Last	c							
60,	icate be executed physicien and s the burial-transit	edical Examiner	resulting in death, cast	Due to (or as a consec	quence or):						
68760,	ifficate g phys es the		•	d							_
Вох	eath certif attending for use e	M/UE	23b. was decedent pregnant	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet		Ectopic pregnancy	,			Date of delivery Month Day Year	
	law requires that the death certil as been signed by the attending 2 should be detached for use e	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 Pregnant at time of a Unknown		Other (specify)				violiti Day 16a.	
9, P.O	res that I	by Ph	Part II. Other significant conditions co	ntributing to death but not re-	sulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use co	entribute to the cause of death?	
ords	v require been sig should b							1 🗆 Y	′es 2□No	3 Probably 4 DUnknown	
Vital Records,	The law rate has be	Completed						24a. Was autop	sy med?	b. Were autopsy findings available prior to completion of cause of death?)
tal	nn: Th trificate tor, pa	0	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes	2 No	1 ☐ Yes 2 No	_
	nysicia nis cert direct	To B	examiner? . /	Hospitat: 1 ☐ tnpatient 2	ER/Outpatier	nt 3□ DOA Oth	00	ome 5 Resid		Other (Specify)	
on of	Attending Physician: or death. actor: After this certific by the funeral director,		27. Mapner of Death 1 Natural 5 ☐ Pending	28a. Date of tnjury (Month, Day Yeer)	28b. Time of Injury	Wor	y at k? Yes 2 □ No	28d. Describe h	low injury occi	urred	
Division	Attenc r death actor: by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of tnjury - At h	nome, farm, str		.00 2 2 7 10			mber or Rural Route Number,	_
Ö	rs after or rs after or ral Dira	Cert	4 Homicide	building, etc. (Speci	y)			City or Tow	ni, State)		
/	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Diractor: After this certificate ha completely filled in by the funeral director, page	edicai		rsician: To the best of my kn iner: On the basis of examin and manner stated.							
	To the within 2 To the complet	Med	29b. Signature and little, J. c. nifier	10 110		29c. Licens	e number	1-2	29d. Date sign	ned (Month, Day, Year)	, 1
)	111	The same of the sa	· CONC	(D) MI)		100	0557	154 (Jaku	1ay 17, 200	1
	51'		30. Name and address of person who c	ompleted cause of death (ite	m 23a) (Type,	Print) MI) Unio	n Mor	navia	1 Hospital El	1)
54	Sta Registi		31. Date filed (Month! Day York) 2	200432. Registrar's Sign	ature	fresh	*****			1-1/	

			State of Maryland / Department of Health and Mer State Certificate of Death		ene 3. No. 2004	00988
	Physicia	an	1. Decedent's Name (First, Middle, Last) Mary Abby Barton	Date of Death Month	Day Year	3. Time of Death 5:55 PM
	/Medic Examin	al	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	anuary	18 2004 4c. County of Death	
			Manor Care Nursing Home Silver Spring		Montgomer	
	Funeral Director		1 M 2 F Months Days Hours Min.	Date of Birth (Month, Day, Y	(ear) Cou	place (State or Foreign intry) ryland
	ס		Usuel Residence of Decedent			10d. Inside City Limits
	Maryla f show	ō				1 Yes 2 No
	h the h	Director	Maryland Anne Arundel Hanover 10e. Street and Number 10f. Zip Code	_	g. Citizen of What Cou	
	s 23a c	raiD	7728 Aragorn Court 21076		14. Race - Ameri	
396	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show othar traumatic event, the Mudical Exacting ment for collined at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No If Yes, Give X Year or Dates: 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Ric 1 □ Yes 2 ☒ No 1 □ Yes 2 ☒ No Specify:	an, etc.)	Black, White	
Maryland 21215-0036	72 hou	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working	16	6b. Kind of Business/Ir	ndustry
121	within ene. then	duc	Elementary/Secondary (0-12) College (1-4or 5+) 12 Bank Teller	T	Building As	ssociation
ם 2	at Hygi other	Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name (F			SSOCIACION
Z∤a।	nould by Ments	To E	Wilbur Dorsey Abby Wil 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural R			n Codol
ā Z	nd 2 shallth and 27 Is n r traun		19a. Informant's Name/Relationship (Type, Print) Janice Kaifer/ Daughter 7728 Aragorn Ct. Hanover			p code)
ore,	es 1 ar of Hea f Item r otha		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Place of Disposition (Name of cemetery, crematory or other place)	20	Oc. Location - City or T	own, State
Baltimore,	permit. Pages. Department of the Important: If Ite any injury or of once.		'4 Donation 5 Other (Specify) Dorsey Family Cem. 1/23/2	2004 Ar	napolis J	unction, MD
Bal	Depar Depar Impor any ir		21. Signature ofneral Service Licensee			
4			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or re shock, or heart failure. List only one cause on each line. Immediate Cause (Final Hungert on Eight	espiratory arres	t,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death) Hypertension Due to (or as a consequence of):			years
E	Examiner	_	Sequentially list conditions, b.			
	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury)			
oʻ	execu an and irial-tra	Exal	that initiated events c. Due to (or as a consequence of):			
8760,	icate be executed physician and s the burial-transit	dlcai	d			
Box 6	death certificate be executed e attending physician and of for use as the burial-transit	n/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 10 line birth 20 Festal death 30 Festa		23d. Date of deliv	very
o.	the y th	Physician/Me	1		Month	Day Year
S, P	es pe	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Senile Dementia, hyperlipidemia, Parkinson's Disease		cco use contribute to	
Sorc	v requir been s should	Completed	Benite Benevita, affering activity furnition b bisease	24a. Was an		
Re	has has	ошо		autopsy performe	prior to co death? No 1 ☐ Yes	opsy findings available ompletion of cause of
ital		Bec	25. Was case referred to medical examiner?			X
of Vital Records,	Phys rthis ral di	. To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d		ce 6 □Other (Speci	ify)
ion	Attending Phyrideath. ector: After this by the funeral.	atior	2 Accident investigation M 1 Yes 2 No			
Division	l or Atten after deat Director:	ertification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f	Location (Stre City or Town,	et and Number or Rur State)	al Route Number,
y	Hospital 4 hours Funeral ely filled	edicai Co	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.			
	To the I	Mec	29b. Signature and title of certifier. 29c. License number	290	d. Date signed (Month,	, Day, Year)
	1) Such (MD) D0056797	J	anuary 20,	2004
	4		30. Name and address of person who completed cause of death (Item 23a) (Type. Print) Lalitha Tadikonda, MD 13952 Baltimore Avenue Laurel, MD	20707		
4	Sta Registi		31. Date filed (Month, Day, Year) JAN 2 0 2004 32. Regisfar's Signature			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				C	ertificate of	Death	,	Reg. No. 2	104	00989
В	hysician	1. Decedent's Name (First, Middle, La					2. Dete of De Month	Dev	Year	3. Time of Death
	/Medical	John Donald Barn						8, 2004		7:00 AM
, E	xaminer	4a Fecility Neme (If not institution, give				4b. City, Town, or	r Location of Deet			
		Lorien Nursing Ho		n yrs. lest birthda		Mount Ai		Carro]		on (Chata as Ensaign
	neral ector		1⊠M 2□F 86	-	Months Days			y, Year)	Country, Maryla	e (State or Foreign) nd
fand	ě =	10a. State 10b. County	10	Oc. City, Town or	Location				10d.	. Inside City Limits
Man	i pi	Maryland Carroll	I N	Mount Ai	rv					1 ☐ Yes 2 🖾 No
death with the Maryland	or 28	10e. Street end Number			10f. Zip Code			10g. Citizen of	What Country	?
ath w	ra la	506 Carroll Ave.			21771			United		
, g	at, or fems 23a or 28a-1 show Examiner must be notified at by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	WWII	3. Was Decedent of If Yes, specify Cub	oan, Mexican, Pue	Specify Yes or No rto Rican, etc.)	Bla	ce-American ck, White, etc y: Whit	
2 bou	natural, dical Exp	15. Decedent's E	ducation	16e. Dec	cedent's Usual Occu	pation	- dita	16b. Kind of B	usiness/Indus	itry
21215-0020 within 72 hours aliene.	nt, the Medical of the Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	life	ve kind of work done . DO NOT use retire	ed)	orking			CO.
ed wi		10th			Truck Dri					ttsburgh
国 图 图	Be ver	17. Father's Neme (First, Middle, Last,					ame (First, Middle		10)	
No N	To To		Barnes	405.14	11: 6 dd (04		e M. Dav		State 7:= 0:	- d-1
Man d 2 st th and	traur	19a. Informent's Name/Relationship (Peggy Hawkins	POA		iling Address (Stree Hobart Ro			17331	State, Zip Co	100)
Fear a	other other	20a. Method of Disposition			position (Name of rematory or other pla		Date	20c. Location -	City or Town	, State
Pages	y or .	1 ☐ Burial 2 ② Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	JHemoval from State		remaiory or ozner piz Cremation		Jan. 19	2004 H	ampeto	ad MD
Daltimor permit. Pages Department of	in in in in in in in in in in in in in i	21. Size re of Funeral Service Licer			22. Name and Addre	ess of Facility				au, rb
n § §	E 8 8	James 18	Cain	22	Burrier-Qu 1212 W. 01	ieen Fune Id Libert	eral Dire	ectors,	PA MD	21784
Exan	dical niner	25a. Part1 Enter the disease, or com shoot, or heart failure. List only Immediate Ceuse (Final disease or condition resulting in death)	a CHROV		Muchus				Or	oproximate terval Between nset and Death
cutec	transi transi	Sequentially list conditions,	bDu	e to (or as a cons	equence of):					
9 9	ourial-	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury	c						1	
requires that the death certificate be executed	as the bural-transit	Ceuse (Diseese or injury that initieted events resulting in death) Last	Due	e to (or as e cons	equence of):					
on the	or use		d							
D ag ag	certificate has been signed by the attendificator, paga 2 should be datached for us be Completed by Physician/	Part II. Other significant conditions of	contributing to death but n	ot resulting in the	underlying cause gi	ven in Part I.	23b. Did	_	ntribute to th	e cause of death?
that t	datac						10	Yes 2□ No	3 ☐ Probab	oly 4 ☐ Unknown
uiras uiras	d by						24a. Was	an autopsy		autopsy findings
COLOS * raquiras	shou						perfo	med?	availa compl of dea	ble prior to letion of cause ath?
The law	paga 2 should						400	on alle		es 2□No
VICEI clan: T	Be C	25. Was case referred to medical				26. Place of De	eath (Check only o	one)		
yalck	To E	examiner? 1 Yes 2 I Yo	Hospital: 1 ☐ Inpatient	2 ER/Outpati	ent 3 DOA Ot	han.	Home 5 ☐ Resid		er (Specify)	
Attending Physician: r death.	e funeral	27. Manner of Death 1 Datural 5 □ Pending 2 □ Accident investigation	28e. Date of Injury (Month, Dey Ye	28b. Time Injury	Wo			how injury occur		
I VISION I or Attending after death.	led in by the funera Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Plece of Injury building, etc. (S	- At home, farm, s Specify)	street, factory, office		28f. Location (: City or Tou	Street and Numb vn, State)	er or Rural Ro	oute Number,
To the Hospital or Attending Phys within 24 hours after death.	Nedical Certification: To Be Commercial Medical Certification of Be Commercial Certification	29a. Certifier 1 2 Certifying Ph (Check only one) 2 Medical Exam	yelcian: To the best of m niner: On the basis of exa and manner stated	amination and/or	ath occurred at the ti investigation, in my	me, date and plac opinion, death occ	e, and due to the curred at the time,	cause(s) and ma date and place,	inner as state and due to the	d. e cause(s)
To the within	d comb	29b. Signature and title of Souffier	M	KD.	29c. Licen.	se number 6499		29d. Date signe		
,	M,	30. Name and address of person who	completed cause of death	n (Item 23e) (Type	e, Print)	11 Driv	e m	FAIN	MI	21771
10	State	31. Dete filed (Month, Day, Year)	32. Registret	Signature	C 0[] 10 10	101,10		1		
j≱ R	egistrar	JAN Z	V 2004 \ AC	Erras D	freet.	P				

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 09:40AM JANUARY 18 2004 Helen Viola Bachman /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HEALTH CAME AGNES BACTIMORE n/a If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (Stete or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) **Funeral** Months 1□M 2∏F Director 101 March 9, 1902 Pennsylvania 220-09-6301 Usual Residence of Decedent Maryland 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show the Medical Exeminer must be notified at 1 ☐ Yes 2√2 No Director Maryland Baltimore Arbutus 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Itama 23a death Funerai 933 Stormont Circle 21227 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerio Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🂢 No Specify: Specify: White þ 3 ☑ Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 8 <u>labeller & bottler</u> distillery nd 2 should be filed wallth and Mental Hygier 27 Is marked other the traumatic event, Its 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should unknown Bricker Mary unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 933 Stormont Circle, Arbutus, Maryland 21227
ace of Disposition (Name of Date 20c. Location - City of Town, S Carolyn Green - granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 1/21/2004 Woodlawn, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) Lorraine Park Cem. 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 1 weeks SEPSIS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisace or highly that initiated events resulting in death) Last Due to (or as a consequence of) be executed burial-transit Exami Due to (or as a consequence of): attending physician 68760 Physician/Medical law requires that the death certificate use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown Month Year Dav 4 Pregnant at time of death 5 Other (specify) 9 Unknown O à ۵ signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy The certificate 1 ☐ Yes 2 X No Division of Vital Attending Physician: funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A death. investigation 2 Accident the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4 - Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and little of centrier 29c. License number 29d. Date signed (Month, Dey, Year) MD P15624 MARCHARL 18 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CHTON AVE BALTMURE, LAWRENCE NO 32. Registrar's Signature 31. Date filed (Month, Day, Year) -State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

An+men

			For	State of Marylan	•		Mental Hygi	ene	. 00001
			Registrar		Certifica	ate of Death	2. Date of Death	g. No. 4 UU &	3. Time of Death
	Physici	an	1. Decedent's Name (First, Middle, Las RAY MOND	JoesepH	RAKU	CVAC	Month	Day Yeer	3. Time of Death
	/Medic		4a. Facility Name (If not institution, give			ity, Town, or Location of Deat	0 /	4c. County of Deat	
	Examin	er		ALGARETE		MONK TON		HARL	ord
	Funeral		5. Sociat Security Number 6. Se	7. Age (In yrs.		der 1 Year If Under 24 Hrs		Year) 9. Birt	hplece (State or Foreign
C	Director		137-50-3380	2M 2□F 49	Yrs.	Days Hours Will	08 07		INSYLUAUS
	pu *		Usual Residence of Decedent 10a. State 10b. County	10c, Cit	y, Town or Location				10d. Inside City Limits
	/anyle	5	mo Hasta		monk	17711			1 ☐ Yes 2 ☐ No
	28a-	Director	10e. Street and Number	4		Zip Code	10	ng. Citizen of What Co	untry?
	3a or	0	2414/ANY1	MRGARET	COURT	21111		U. Sol	1
	death	by Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13. Was De	cedent of Hispanic Origin? (Specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - Ame Btack, White	
စ္	after or ite	F.	1 Never Married 2 Married	1 Tes 2 2 No		2 No Specify:	to racan, etc.)	Specify:	e, etc.
21215-0036	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or tems 23a or 28a-1 show ent, the Medical Examiner must be notified at	d b	3 Widowed 4 Divorced	Year or Dates:				u	hite
<u>7</u>	"nat	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Decedent's U (Give kind of life. DO NO	work done during most of wo	orking	6b. Kind of Business/	Industry
72	withiu ene. then	dwc	Elementary/Secondary (0-12)	College (1-4or 5+)	1	SALESMAN		Excee GATT	10
	Hygi other	0	17. Father's Name (First, Middle, Last)	3-97-3	1		me (First, Middle, M		
an	Mental Mental arked o	To B	VITO BAK	UCKAS		Dolo	ers M	eron	
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic svent, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailing Addr	ess (Street and Number or R	ural Route Number,	City or Town, State, 2	Zip Code)
	1 and 2 Health em 27 i	1 3		CAS (WIFE)		407 miller			
ore	of He		20a. Method of Disposition 1 Burial 2 Cremation 3		Place of Disposition (emetery, crematory of	Name of or other place)		Oc. Location - City or	
Ē	Pa ant any		* 4 □ Donation 5 □ Other (Specify	We We	st Armely	Crevets 01-	21-2004	Oderton	mo
Baltimore,	permit. Pages 1 av Department of Hea Importent: If item any injury or other		21. Signature of Funeral Service Licen	1///	22. Name	and Address of Facility	- 1 :====	- 1	***
	40244		23a. Part1. Enter the disease or comp	ML M0773	h Do not enter the o	note of dving such as cartila	cor respiratory arre	st way pr	Approximate
			shock, or heart faffure. List onty	one cause on each line.		META)TA			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a conseq		יו נג וויושריו	1/		3 mm/ W
	Examiner		f		33.133 317.				
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):				
	cate be executed ohysician and the burial-transit	Examiner	that initiated events	c					
0	oe exe cian a rurial-	I Ex	resulting in death) Last	Due to (or as a conseq	uence of):				
8760,	cate be executed physician and s the burial-transit	dical		d					
9 X	the death certific y the attending p sched for use as	/Me	IF FEMALE:	23c. If yes, outcome of pregna	ancy			23d. Date of deli	NAD!
Вох	atten after of for u	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fete 4 ☐ Pregnant at time of d		pregnancy (specify)		Month	Day Year
P.O.	that the de ed by the detached	hyst	9 Unknown	9□ Unknown					
	The law requires that ate has been signed b page 2 should be deta	by Physician/Me	Part II. Other significant conditions of	entributing to death but not res	ulting in the underlyin	g cause given in Part I.	23e. Did toba	acco use contribute to	
ğ	w require been sig should b	ed					1 🗆 Yes	s 2□No 3□Pre	obabiy 4 Unknown
Division of Vital Records,	ne law re has be ge 2 shu	Completed					24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
- H		Con					perform 1 ☐ Yes 2	ed2 death? XNo 1⊟Yes	2□ No
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othor	ath (Check only one		
of	Physical direction	٦.	1 Yes 2 No 27. Manner of Death	1 Inpatient 2 28a. Date of Injury	ER/Outpatient 3☐ 28b. Time of	7	Home 5 Resider 28d. Describe how	nce 6 Other (Spec	cify)
O	ding h. After funet	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	200. 0030100 1104	ritary occurred	
IS	Attending r death.	fica	3 Suicide 6 Could not be	289. Flace of injury - At Hi	ome, farm, street, fac		28f. Location (Stre	eet and Number or Ru	ral Route Number,
ă	el or / s after il Dire	Certification:	4 Homicide determined	building, etc. (Specif	y)		City or Town,	State)	
7/	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifying Ph	sician: To the best of my kno	wiedge, death occurr	ed at the time, date and place	e, and due to the car	usa(s) and manner as	stated.
	the H iin 24 the Fi ipletel	Medical	one)	iner: On the basis of examina and manner stated.					
	To To To Com	2	29b. Signature and title of certifier			29c. License number	29	d. Date signed (Month	n, Day, Year)
	1 -		5000			26/13		1/17/	- /
	10		30. Name and address of person who o	completed cause of death (Item		02773.	ohs. 40	21209	1
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa		7 /0/11/1	/ (/		
	Regist		週間 0 6 2 6	. #	and the same of th	1 .			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				C	ertificate	of Death		Reg. No. 2 (04	00992
	Physician	1. Decedent's Name (First, Middle, Las	1)				2. Date of De Month	eth Dey	Year	3. Time of Death
	Physician /Medical	Ruth Caroly:	n Beard				Januar	•	2004	2:00 PM
, , , , , , , , , , , , , , , , , , ,	Examiner	4a Fecility Name (If not institution, give	street and number)			4b. City, Town,	or Location of Death	4c. County		
		Lorien Nursing	& Rehabili	tation	n Cent	er Belca	qm	Наз	rford	
	Funeral	5. Social Security Number 6. Se	7. Age (In y	rs. lest birthda) If Under 1		rs. 8. Date of Birt	h		e (State or Foreign
	Director	216-28-3015	□M 2XIF 90	Yrs.	North	Days Hours IV		. 1913	Maryla	
	0	Usuel Residence of Decedent						, <u> </u>		
	ylen how	10a. State 10b. County	10c.	City, Town or	Location				10d.	. Inside City Limits
	to the state of	Maryland Harford	F	el Air						1 ☐ Yes 2 No
		10e. Street end Number	-	1111	10f. Zip C	ode		10g. Citizen of	What Country	?
i	eth with the Maryler 123s or 28s-f show wat be notified at rail Director	930 Felicia Court			210	11/		LICE	^	
)	1 2 FE	11. Marital Status	12. Was Decedent Ever in	U,S. 13		nt of Hispanic Origin? y Cuban, Mexican, Pu	(Specify Yes or No	US/ 14. Rad	e - American	
50	72 hours enter deeth with the marylend naturel", or items 23e or 28e-1 show dical Examiner must be notified at etch by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 Æ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates:			y Cuban, Mexican, Pu No <i>Specify:</i>	erto Rican, etc.)	Specify		
Ģ .	n 72 nours "natural", adical Ex adical Ex	15. Decedent's Edu		16e Dec	edent's Usual	Occupation		16b. Kind of B		nite
21215-0020	be filed within 72 ho tel Hygiene. I other then "naturing went, the Medical Be Completed	(Specify only highest great	le completed)	(Giv	e kind of work DO NOT use	done during most of v	vorking	TOD. KING OF D	usinessaniuus	iu y
12	within ene.	Elementary/Secondary (0-12)	College (1-4or 5+)							
	S F S	12 17. Father's Name (First, Middle, Last)		ASS	empth r	ine Worker	ame (First, Middle,	Communi		ıs —
Ĭ.	B Selection		G !						10)	
<u> </u>	z should be filed within end Mentel Hygiene. Is marked other than aumatic event, tre M. To Be Comp	John Henry	Cunningha			Margar		arbara_	Kra	
	end in m	19a. Informant's Name/Relationship (T)				Street and Number or				
	end selfh mar tu	Barbara L. Pohl -	-			a Court, E	Bel Air, N			
ore.	T to t	20a. Method of Disposition 1 ☐ Burial 2 □ Cremation 3 ☐ F	20t	o. Place of Disp cemetery, cr	oosition (Name ematory or oth	of er place)	Date	20c. Location -	City or Town	, State
Ě	ing in it.	4 □ Donation 5 □ Other (Specify)	Hi	lltop s	Service	Corp.	1/20/04	Towson -	Marrol	and
Baltimore,	permit. Feges 1 and 2 should be lined within 72 hours Department of Hellth and Mantel Hygiene Important: If Item 271 a marked other than "natural; any Injury or other traumatic event, the Madical Exp phice. To Be Completed by	21. Signature of Funeral Service Licens					McComas I			
<u>~</u>	Depe impo	Market Ra	2 -			okesbury F	oad, Abir	ngdon, M		
		23a. Pert1. Enter the disease, or composhock, or heart failure. List only o	lications that caused the de ne cause on eech line.	eath. Do not e	nter the mode	of dying, such as card	iac or respiratory ar	rest,	i Ini	pproximate terval Between
	hysician		Λ		. 0	-	1 -		O	nset and Death
	/Medical	Immediate Cause (Final disease or condition	. Inuc) car	dial	intaro	Dun		:	
	Examiner	resulting in death)	1	(or as a cons			(1	
	je								0 2	
	instant requires the rine operin certificate be executed. It is a set of the control of the con	Sequentially list conditions.	Due to	(or as a cons	equence of):					
o		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events							į	
68760,	S ysici	that initieted events	CDue to	(or as e conse	quence of):					
အမှ	ng ph	resulting in death) Last							i	
Вох			d							
Δ0	d for	Pert II. Other significant conditions con	atributing to death but not r	aculting in the	undodvina cau	so given in Part I	22h Did t	obacco uso co	ntribute to th	e cause of death?
о. О	y the	Fert II. Other significant conditions con	itributing to death but not i	esulling in the	undenying cau	se given in Part i.		10		
م ا	dete dete						10,	(ee 2 KNo	3 Probab	oly 4 □ Unknown
of Vital Records,	the taw requires thet the death certical has been signed by the ettending page 2 should be deteched for use Completed by Physician/N						24a Was	an autopsy	24b Were	autopsy findings
ក្ត	med houl						perfo	med?	availa	ble prior to letion of cause
9	hes t ye 2 s								of dea	
<u> </u>	ete peg						101	ss 2□No	1□Y	es 2 No
ig ig	certificete rector, peg	25. Was case referred to medical examiner?				26. Place of D	eath (Check only o	ne)		
of Vita	this ce al dire	1 Yes 2 No	dospital: 1 Inpatient 2	☐ ER/Outpeti	ent 3 DOA	Other: 4 Nursing	Home 5 ☐ Resid	ence 6 □Oth	er (Specify)	
	erth ieral	27. Menner of Deeth	28e. Dete of Injury (Month, Dey Year)	28b. Time Injury	of 28c	Injury at Work?	28d. Describe h			
<u>o</u>	atio	1 Naturel 5 Pending 2 Accident investigation	(Month, Dey rear)	injury	М	1 ☐ Yes 2 ☐ No				
Division	r death. ctor: After by the fune	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - Al	home, farm, s	treet, factory, o	office	28f. Location (S	treet and Numb	er or Rural R	oute Number,
á	Attentions of state o	4 Homicide	building, etc. (Spe	cify)			City or Tow	n, State)		
1	To the Troughter of Authoriting Priyatodan. The re- within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, pege Medical Certification: To Be Com	(Check only 2 Medical Exam)	sician: To the best of my k ner: On the basis of exami	nowledge, dea	th occurred at	the time, date and pla my opinion, death oc	ce, and due to the c curred at the time.	ause(s) and ma	inner as state	nd. e cause(s)
4	the f	one)	and manner stated.							
	To this	29b. Signature and title of certifier	111		29c. L	icense number	- :	29d. Date signer	(Month, Day	r, Yeer)
		1 96 (1	July	WIN	$- \mid f$	127971	*	1119	104	
_	V	30. Name end eddress of person who co	empleted cause of death (II	em 23e) (Type	, Print)		1	1 (- /	1	
4	7	DAMA A	1 Clour an	1 6/3	Mar	Christ No	9 MAIT	the Mi	n2101	4
3	State	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	1	4				1
	Registrar	JAN 2 0 2	1711 Dener	me ,	9	2 .				

DHMH 16 Rev 6/95

			•	For State Registrar		State o	of Maryla		artment rtificate		ealth and I Death	Mental Hy	/gier Reg. 1	Z 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	00993
				Decedent's Name (F	îrst, Middle, La	st)						2. Date of D	eath		3. Time of Death
		hysicia /Medic		James	Edmond	Во	oth					Januar	у 1	$\overset{\text{Pay}}{4}$, $20\overset{\text{Year}}{04}$	16:15 M
		xamin		4a. Facility Name (If no							Location of Death	h	4	c. County of Death	
				Upper Ches					BeL If Under 1	Air	If Under 24 Hrs.	9 Date of B		Harford	
		neral ector		5. Social Security Numb 215-26-05	71 !	ex □M 2□F	7. Age (in yrs	. last birthday) Yrs.	Months	Days	Hours Min.	8. Date of B (Month, D March	29°,	1930 Wash	ace (State or Foreign try), ington, DC
	pue	-	-	Usual Residence of De 10a. State 10	cedent b. County		10c. C	ity, Town or Lo	cation						Od. Inside City Limits
	death with the Maryland	notified at	ō	Maryland	Harfor	4	J	oppa							1 ☐ Yes 2 ☐ No
	the :	Tigot I	Directo	10e. Street and Numbe		<u> </u>		эрри	10f. Zip (Code	-		10g. (Citizen of What Coun	try?
	th with	athe		640 Harboi	rside D	rive			210	085			US	A	
5	· 6	voicel Examiner must be notified at	Funeral	11. Marital Status 1 ☐ Never Married	2 Married	Armed Fo	2 No		_		panic Origin? (Sp., Mexican, Puerto	pecify Yes or N o Rican, etc.)	D-	14. Race - America Black, White, e	
0	5-0036 72 hours after	Exa	ρ	3 Vidowed 4	Divorced	If Yes, Gr Year or D	ates:		1 ☐ Yes 2	ASJ NO	Specify:			Specify: Wh:	ite
1	Baltimore, Maryland 21215-0036 semit. Pages 1 end 2 should be filed within 72 hours all beginnent of Heelth end Mental Hygiene.	affice	Completed		Decedent's Ed only highest gra			16a. Dece	dent's Usual kind of work	Occupat k done de	tion uring most of wort	king	16b.	Kind of Business/Ind	ustry
	O E	\$	dmc	Elementary/Seconda	ry (0-12)	College (1-4or 5+)				ic Accou		А	ccounting	
	D B	T I		17. Father's Name (Firs	t, Middle, Last)			CCLCI	1100		18. Mother's Nam		1		
	lan) Sign	To Be	Homer	Tyndal]	. В	ooth				Edith	Ion	е	Beyer	
	ary shou	Ē	7	19a. Informant's Name	Relationship (Гуре, Print)		19b. Mailir	ng Address ((Street a	nd Number or Ru	ral Route Numb	er, City	or Town, State, Zip	Code)
2	end 2	er tra		James N. E		Son		504 Place of Dispo	Echol	s Co	urt, Jo	opa. Ma		and 21085	
10	Ore	to		20a. Method of Disposit 1 ☑ Burial 2 🗀 Ci		Removal from	State	cemetery, crer	natory or oth	ner place	<i>'</i>	Date	20c.	Location - City or Tov	vn, State
14	timen true	duy		4 Donation 5 □	Other (Specify)	st				h. 1/19			erdeen, Ma	
-	Baltimore, Maryland 21: permit. Pages 1 end 2 should be flied will Department of Heelth end Mental Hygien	Dice.		21. Signature Florers	I Service Licen	see			Name and					neral Home on, Maryla	•
			\dashv	23a. Fart I. Enter the d	isease, or comi	olications that of	eused the dea								
	A SECOND			shock, or heart fail	lure. List only	one cause on e	each line.								Approximate Interval Between Onset and Death
•	Pnys /Me	dical	-	disease or condition resulting in death)	•		(or as a consec		IVo	NSI	MARLL	CELL	اللا	VOLCANICE	R 6 MONTH
	Exan	niner		Casuantially list conditi		J	EJUN	AL	PER	FOF	RATION	5		3	SWKS
0.	7 0	=	<u>a</u>	Sequentially list condition any, leading to immediate. Enter Underlyin Cause (Disease or injure)	diate g		(or as a consec	quence of):							
25	ecute 7	tra	Examine	Cause (Disease or injul that initiated events resulting in death) Last	У	-	RAIN_ (or as a consec		TAS	rAS	15				NK .
0	8760,			• ,			(01 43 4 0011301	(4 01100 01).							
#	X 6876	as the	edical			. d									
L	Box	for use as	clan/Med	IF FEMALE: 23b. Was decedent pre		23c. If yes, out	tcome of pregn		Ectopic pred	ananev				23d. Date of deliver	,
		hed for	8 S	in the past 12 mor 1 ☐ Yes 2 ☐ No			ant at time of		Other (spec					Month [Day Year
ठं	- ±	, a	Phys	9 ☐ Unknown Part II. Other significan	t conditions o		anth but not so	udtion in the			in Donal	age Did	-bassa	use contribute to the	anuan of damb?
Inches	ds,	8 .	ا ۾	0	SEMA	minouning to de	eath but not res	sulling in the ur	iderlying cat	use given	in Pan I.	112	,		bly 4 DUnknown
70	Records,	should	Completed	Civile	2011							<u> </u>			, _
F	Rec as a series	9 5	Ē.									24a. Was autop		prior to com death?	sy findings available pletion of cause of
()		or. pa		25. Was case referred t	o medical						26. Place of Deat	1 ☐ Yes	2 N	0 1 ☐ Yes 2	No.
છું			To B	examiner? 1 ☐ Yes 2 ☑ No		Hospital: 1 🗹	Inpatient 2	ER/Outpatien	: 3 ☐ DOA					6 ☐Other (Specify)	
- ณฑes	on of	- "		27. Manner of Death	C Dooding	28a. Date		28b. Time of Injury		c. Injury a Work?	ıt	28d. Describe			
5	ISION Itendin death.	he fur	atic	2 Accident	Pending investigation			,,	М		s 2 🗆 No				
~	Division of attending after death.	in by t	Certification;	3 ☐ Suicide 6 4 ☐ Homicide	Could not be determined	28e. Place buildi	of Injury - At h	ome, farm, stre y)	et, factory,	office		28f. Location (3 City or Tox		nd Number or Rural i e)	Route Number,
Booth,	Division Hepitel or Attending 24 hours after death.			29a. Certifier 1	Cartifying Phy	sicien: To the	hest of my kno	wledge death	occurred at	the time	date and place	and due to the	221122/1	and manner as sta	
200	14 H	ietely	Medical	(Check only 2	Medical Exem	iner: On the ba	asis of examina ner stated.	ition and/or inv	estigation, in	n my opir	nion, death occur	red at the time,	date an	d place, and due to t	he cause(s)
0	To the within 2	due	¥	29b. Signature and title	of certifier				29c. l	License r	number	1		ate signed (Month, D	
	2	1		H.	Leuo	vacil	an	M.D	P	HE	5530		01	-15-	2004
•	10			30. Name and address	of person who	ompleted caus	_	n 23a) (Type, I						ة باليا تسون	40-21236
	v			3 SIUI	ASAIL	AM	8714		DETE	FR	CIKCL	t, s	ULT	rt alli	40-21236
	В	State egistra	Ç	31. Date filed (Month, D			egistrar's Signa	iture .			*				
	DHMH 17	_		JA	¥ 2 0 2	104	CEANA	19	1	,	*				
								PIGINAL	Spo	ac.	1				

			for State Registrar	State of Maryland	-	artmen rtificat			nd Mei		ene	2004	00991
	Physici /Medic Examir	al	Decedent's Name (First, Middle, Last Claudy Wilbert By Escility Name (If not institution, give Union Memorial	yrd		4b. City, Balt		Location of	Death	Date of Death Month	Day	2001 unty of Deat	3. Time of Death 7:22 AM
	Funeral Director		5. Sociel Security Number 241-44-6037 Usual Residence of Decedent	x	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	4 Hrs. 8. Min.	Dete of Birth (Month, Dey, 2C. 2,	1932	Co	hplece (Stete or Foreign untry) :h Carolina
	ith the Maryland or 28a-f show a notified at	Olrector	10a. State 10b. County MD N/A 10e. Street and Number	Balt	imore	10f. Zip				10	g. Citizer	of What Co	10d. Inside City Limits 1 X Yes 2 □ No untry?
036	within 72 hours after deeth with the Maryland ene. then "naturel", or iteme 23e or 28a-f ehow I.a Mezical Examirer mast te motilled at	by Funeral Director	3738 Hickory Aver	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates:		Was Deced If Yes, spec	dent of Hi orly Cuba	spanic Origi n, Mexican, Specify:	in? (Specif Puerto Ric	y Yes or No- an, etc.)		Race · Ame Black, White ecity:	
Maryland 21215-0036	iled within 72 ho tygiene. her then "natur nt, tre Medical	Completed	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	de completed) College (1-4or 5+)	16a. Dece (Give life. Plumbe	kind of wo DO NOT us	rk done o	furing most			1umb		Industry
aryland	should be find Mental H marked of umatic ever	To Be	Strange Vance Byr 19a. Informant's Name/Relationship (7)		19b. Maili	ng Address	(Street a	Dora	Eliza	abeth Li	ane	n ni	Tip Code)
Baltimore, Ma	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Heelih and Mental Hygiene. Important: If item 27 is marked other then "naturat, or iteme 23e or 28a-f show any injury or other traumatic event, the Medical Examinet must be notified at ADGE.		Lisa Marie Byrd 20a. Method of Disposition 1 Burial 2 Discremation 3 Fig. 4 Donation 5 Other (Specify) 21. Signature of Impray Service Lipens	Removal from State	ace of Dispo emetery, crei top S	ervic	ne of ther place e Co	θ)	/20/0		Oc. Locat	n, MD	Town, State
	Physician /Medical Examiner		23a. Pert 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	lication that caused the death one dayse on each line. A C 17 E Due to (or as a consequence)	MYUC	ter the mod	le of dying		ardiac or re			wson,	MD 21204 Approximate Interval Between Onset and Death
,092	ate be executed hysicien and the burial-transit	ical Examiner	Sequentially list conditions, if any, reading to minious accounties. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence. Due to (or as a consequence.									
.O. Box 68	nding puse as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pr					23d	. Date of deli Month	very Day Year
S, D	w requires that the death been signed by the atte should be detached for		Part II. Other significant conditions co	ntributing to death but not result	alting in the u	nderlying c	ause give	en in Part I.			cco use		the cause of death?
of Vital Record	iician: The law ri certificate has be rector, page 2 sh	Completed									ed? No	4b. Were au prior to death?	topsy findings available completion of cause of 2 No
₹	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			Othe	30		heck only one			
ion of	ling After fune	ation: To	1 Yes No 27. Manner of Death 1 Valural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yeer)	28b. Time o Injury		8c. Injury Work		280	5 Resident Describe how			sity)
Division	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the i	Certification:	3 Suicide 6 Could not be determined	building, etc. (Specify	·)					City or Town,	State)		ral Route Number,
	24 ho Fund Hely t	edicai	29a. Certifier 1 Sertifying Phy (Check only one) 1 Medical Exam	rsician: To the best of my know iner: On the basis of examinat and manner stated.	wiedge, deat ion and/or in	n occurred vestigation	at the tim , in my of	ie, date and pinion, death	place, and n occurred	at the time, dat	ise(s) and le and pla	d manner as ice, and due	stated. to the cause(s)
	To the To the comple	Me	29b. Signature and title of certifier	mo		290	i. License	1715		29	d. Date s	/	n, Day, Year)
_	10		ICOT III	MA 3730	FA		2,00	BA	LTIMU	RE A	Δ	21211	
1/4	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	0							

			1 _ State	Department of Health and N Certificate of Death	lental Hygi	ene 2001	. 00995
		-	Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death	2. Date of Death	g. No.	3. Time of Death
	Physic	an	A POST COLOR DE LA SECTION DE LA COLOR DE		January	Day Year	8:45 P M
	/Medi		Lillian D. Blakeslee	Ab City Town as leasting of Dooth	ualluar y	15, 2004	
	Examir	ner	4a. Facility Name (If not institution, give street and number) Oak Crest Care Center	4b. City, Town, or Location of Death Parkville		4c. County of Deal Baltimore	,n
			5. Social Security Number 6. Sex 7. Age (In yrs. last to		8 Date of Birth	1	hologo (State or Foreign
	Funeral		577-28-6338 1 M 2 1 F 94	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Sept 25	, 1909 Mar	hplace (State or Foreign funtry) 'y land
	Director		Usual Residence of Decedent		Jept 23	, 1505 Hai	yrana
	land ow		100 000	wn or Location			10d. Inside City Limits
	Mary	ξ	MD Baltimore Timor	nium			1 ☐ Yes 2 🖔 No
	1 28s	rec	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	ountry?
7	h with	0	10 Collis Court	21093		USA	
7	deatl	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	
~ "	after or Ite	Ē	1 Never Married 2 Married 1 Yes 2 No If Yes, Give	1 ☐ Yes 2 🖔 No Specify:	rican, etc.)	Black, Whit	e, etc.
-1// 19 M	72 hours after death with the Maryland natural; or Items 23a or 28a-f show dical Examinar must be notified at	Completed by Funeral Director	3 ☐XWidowed 4 ☐ Divorced Year or Dates:	To les 22 No Specify.		Specify: Wh	ite
- 7	72 h natu	etec	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing 1	6b. Kind of Business/	Industry
7 2	within ene. then	idu	Elementary/Secondary (0·12) College (1-4or 5+)	,		0 11	
~ 5	filed w Hygier other th	S		lomemaker	(F) -1 46'-4' 1 41	Own Home	
	ital H d oth	To Be	17. Father's Name (First, Middle, Last) Fred Davis	18. Mother's Name Josephir		alden Sumame)	
07 =	2 should be filed within and Mental Hygiene. Is marked other than reumatic event, the Mental county.	2				a	
S /ee , Lilli Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylar at of Health and Mental Hygiene. If it is fleatiff and Mental Hygiene "retural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at			b. Mailing Address (Street and Number or Run) Collis Court; Timoni		City of Town, State, 2 21093	up Code)
	permit. Pages 1 and 2 Department of Health a Important: If item 27 is eny injury or other tra					0c. Location - City or	Town State
S/ake	in it it		Burial 2 Deremation 3 Premoval from State	ery, crematory or other place)	_		Tomi, Olulo
af	t. Partmer			Service Corporation 1/19/ 22. Name and Address of Facility	04 1	owson, MD	
	Depar Depar Impo		21. Signature of Fuheial Service Ligensee		Home	1050 York	
(T)			22a Bart 1 Sator the disease or complication that caused the death. Do	Ruck Towson Funeral		Towson, f	Approximate
			23a. Part1. Enter the disease, or complication, that caused the death. Do shock, or hear failure. List only one care on each line.	of the mode of dying, such as cardiac of	or respiratory arres	51,	Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	entia			
	Examiner		Due to (or as a consequence	9 of):			
1-		ē	Sequentially list conditions, Tarry, leading to immediate cause. Enter Underlying Cause (Disease or injury	a जी:			
27	uted d ansit	Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events c.				
of the	be executicien and burial-tra	Exa	resulting in death) East Due to (or as a consequence	of):			
760.	te be executed ysicien and he burial-transit	cai	d				
45	tificat ng ph	edi					
Box	h cer andir use	Ş	IF FEMALE: 23b. Was decedent pregnant 1 □Live birth 2 □ Fetal deat	h 3 Ectopic pregnancy		23d. Date of deli	,
	deat	Sicia	1 Yes 2 Do	5 Other (specify)		Month	Day Year
0	The law requires that the death certificate ten has been signed by the attending physoage 2 should be detached for use as the	Physician/Medi	9 Unknown				
7 0	es th gned be de	þ	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.		acco use contribute to	
0	equir sen s ould	ted	_ Coronial Hoppinion	~)(0V	1 Yes	2 1 0 № 3 🗆 Pro	obably 4 Unknown
5 /04	as be	pie	V I		24a. Was an autopsy	24b. Were au	topsy findings available ompletion of cause of
	The ate h page	Completed			performe 1 ☐ Yes 2	ed? death?	2 🗆 No
ital	ician: The lav certificate has rector, page 2	Be (25. Was case referred to medical examiner?	26. Place of Death	(Check only one)	
of	Physician: this certific	2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/C	The second secon	me 5□Residen	ce 6 Other (Spec	rity)
	ding Phy h. After thi funeral	on:	1 Natural 5 Pending (Month, Day Year)	Injury Work?	28d. Describe how	injury occurred	
9 5	Attending r death. ector: After	cat	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	ORE Leasting (Chris	and and Alicenters of Co.	-10
ired	or Attendate death Director: A	ertif	4 Homicide determined 28e. Place of Injury - At home, 1 building, etc. (Specify)	arm, street, factory, onice	City or Town,	et and Number or Ru State)	rai Houte Number,
0	To the Hospital or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	Medical Certification:	29a. Certifier 1 Certifying Physician: To the best of my knowledge	ge, death occurred at the time, date and place	and due to the car	ise(s) and manner as	stated.
111	• Ho: • Fut letely	dic	(Check only 2 Medical Exa iner: On the basis of examination a one)	nd/or investigation, in my opinion, death occurr	ed at the time, dat	e and place, and due	to the cause(s)
HUI	To the within 2 To the comple	M	29b. Signature a of certifier	29c. License number	290	d. Da e signed (Nonth	. Day, Year)
				D35685		11 (6/0)	+
	4		30. Name and address of person who completed cause of qualif (Item 734)	(Type, Print)	17 -	1-211	<u> </u>
_			28 00 mm 121 ng	rankville t	W a	11074	
	Sta		31. Date filed (Month, Day, Year) 732. Registrar's Signature				
	Registi	ar	JAN 2 0 2004	Can. 189 a			

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar			epartment o Certificate			Reg. N		00996
	Physici /Medio Examin	al	4a. Fecility Name (If not institution, gi	nner re street and number)		4b. City, To	wn, or Location	Mon	ay 1.	Year 2004 C. County of Death	3. Time of Death 22: 17 M
	Funeral Director		214 44 5191		e (In yrs. last birth	If Under 1 \ Months D	Year If Under ays Hours	er 24 Hrs. 8. Date	of Birth th, Day, Yea Ch 2,	Not App 9. Birth 1946 M	lichble place (State or Foreign intry) aryland
	Maryland -f show	tor	Usuel Residence of Decedent 10a. State 10b. County Maryland N/A		10c. City, Town	or Location					10d. Inside City Limits 1 Yes 2 No
	th with the 23a or 286	Funeral Director	10e. Street and Number 1300 S. Ellwoo	d Avenue		10f. Zip Co	^{de} 21224		10g. (U.S.A.	
036	within 72 hours after death with the Maryland ene. Than "natural, or tlems 23a or 28e-f show he Madical Examinar must be notified at	5	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 X I If Yes, Give Year or Dates:		13. Was Deceden If Yes, specify 1 Tes 2		Origin? (Specify Yes an, Puerto Rican, el y:	or No-	14. Race - Amer Black, White Specify: W	
21215-0036	d within 72 ho jiene. ir than "natui ine Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 1 2 th	ducation ade completed) College (1-4or 5	(4)	Decedent's Usual C (Give kind of work of life. DO NOT use i Sales Cle	fone during m etired)	ost of working		Kind of Business/I	
Maryland ?	ould be filed Mental Hyg arked othe atto event,	To Be C	17. Father's Name (First, Middle, Las James	Newman				her's Name <i>(First, A</i> Estelle S	chenk	elberg	
ore, Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatilt and Mental Hygiene. Important: if Item 27 is merked other than "natural; or Items 23a or 28e-f show any fujury or other traumatic event, the Mudical Examiner must be notified at once.		19a. Informant's Name/Relationship Joseph Bunner 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 6	/ Husband	49	Mailing Address (S Transvet Disposition (Name r, crematory or othe	se Way	Date	Rive	r, Maryla Location - City or 1	ind 21220
Baltimore,	permit. Pag Department Important: b any Injury o		*4 Donation 5 Other (Special Signature of Funeral Service Lice	(fy)	Cresti	awn Ceme	ddress of Fac	1/19/200 George J	. Gonc	rriottsv e Funera	ille, MD 1 Home, P.A yland 21225
	Pnysician /Medical Examiner	Iner	23a. Part1. Enter the disease, or or shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. The Due to (or as	a consequence o	n):	f dying, such a	as cardiac or respira	tory arrest,		Approximate Interval Between Onset and Death United States
	death certificate be executed e attending physicien and d for use as the buriat-transit	Physician/Medical Examiner	that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	d	2 Fetal death	3 □Ectopic pregi				23d. Date of delin	very Day Year
P.0	that the c ed by the detached	by Physic	1 ☐ Yes 2 No 9 ☐ Unknown	4 □ Pregnant at 9 □ Unknown contributing to death b		5 🗌 Other (speci	-	t I. 23e	. Did tobacco	o use contribute to	the cause of death?
Records,	e law requ has been je 2 shoul	Completed b							1 ☐ Yes Was an autopsy performed? Yes 2 2 € 1	prior to c death?	topsy findings available ompletion of cause of
Division of Vital	ng Physician: fter this certific ineral director.	To Be	25. Was case referred to medical examiner? 1 Yes	Hospital: 1 Inpatie 28a. Date of Inju (Month, Da		patient 3 DOA 28c.	Other	ce of Death (Check Nursing Home 5 28d. Des	only one) Residence		
Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Attencompletely filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not 4 Homicide determine	be gen Bloom of Ini	ury - At home, far c. (Specify)	m, street, factory, o		28f. Loca	ition (Street or Town, Sta	and Number or Ru te)	ral Route Number,
	the Hospiin 24 hour the Funer spletely fills	Medical	(Check only 2 Medicel Exa	hysicien: To the best miner: On the basis of and manner sta	f examination and	Vor investigation, in	my opinion, d	eath occurred at the	time, date a	nd place, and due	to the cause(s)
,	To t To t	W	29b. Signature and title of certifier 30. Name and address of person who	7 00-00	M - D . leath (Item 23a) (29c. L	P 164	81	29d. [Date signed (Month	, Day, Year) 15, 2004
	Sta Regist	ate	1 1 1	rm.a. m	Percy h	redical A	Cente-	30154	Paul t	lace Isalt	15,2004 more MD 2120

			1 - For Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of l			iene 200	4 00997
			1. Decedent's Name (First, Middle, La	st)				2. Date of Dea	th Day Yea	3. Time of Death
	Physici /Medi		Lillian		Brocki			Jan.	19 200	/ FO M
	Examir		4a. Fecility Name (If not institution, giv	e street and number)		4b. City, Town,	or Location of Deatl	1	4c. County of De	eth
			Stella Maris			Timor			Baltimo	re
	Funeral		Social Security Number 6. S	ex 7. Age ☐ M 25 F	(In yrs. last birthday,	Months Days		(Month, Day	Year) 9. B	irthplace (State or Foreign Country)
п	Director		213-10-0399		89 Yrs.			Nov. 4	,1914 Mai	ryland
	bus *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	tanyli sho	৳		10	Baltimor	•0				1 ∑Yes 2 □ No
	the A	Director	Mary Land n	/a	Daitinoi	10f. Zip Code	···	1	0g. Citizen of What (Country?
	with a					21212			U.S.A.	•
	leath	Funeral	6311 Blackburn (12. Was Decedent 8	Ever in U.S. 13.		Hispanic Origin? (S	pecify Yes or No-		nerican Indian,
	fter d	핊	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ N	lo i		Hispanic Origin? (S ban, Mexican, Puert	o Rican, etc.)	Black, Wh	site, etc.
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than *natural*, or Hems 23a or 28a-1 show event, the Medical Examinal must be notilized at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give 25 Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify:	White
Õ	2 ho	Completed	15. Decedent's E		16a. Dece	dent's Usual Occu	pation during most of wor	tina	16b. Kind of Busines	s/Industry
21	within 7 ene. than *r	ple	Elementary/Secondary (0-12)	College (1-4or 5	life	DO NOT use retire	ed)	All 19	11. 0	0
	filed wi Hygien sther th	Con		4	C1	erk	7			Government
ם	tal Hy d oth	Be	17. Father's Name (First, Middle, Last,				18. Mother's Nan	ne (First, Middle, I	Maiden Surname)	
<u>ya</u>		ို	Adam	Brocki			Mary		Kurowski	
Maryland	s 1 and 2 should f Health and Mer Itam 27 is marke other traumatic		19a. Informant's Name/Relationship (City or Town, State,	
	1 and Health am 27 Ither to		Miss Dorothy Broc	ki (sister)					Maryland2	
Ore	60		20a. Method of Disposition 1 Description 2 Cremation 3 C	Removal from State	20b. Place of Dispo cemetery, cre-			50	20c. Location - City of	
Ë	Peg men tant: jury		' 4 ☐ Donation 5 ☐ Other (Specification)				emt. $1-2$	1-04	Baltimore,	Maryland
Baltimore,	permit. Pege Department Important: If any Injury o		21. Signature of Funeral Service Licer	ISOO A	2	2. Name and Addre Mitchel	ess of Facility .1-Wiedefe	eld F.H.	Inc.	
_	0 □ F ∈ 0		Golder -	· Buch)	6500 Y	ork Rd. I	Baltimore	Inc. Maryland	21212 Approximate
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a. CF A Due to (or as a Due to (or a) Due to (or	BAU AS a consequence of):		DISTE.			interval Between Onset and Death
68760,	icate be executed physicien and s the burial-transit	edical Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a	a consequence of):					
.O. Box	es that the death certifica igned by the attending pt be detached for use as t	Physician/Med	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 24 Pregnant at 9 Unknown	2 Fetel death 3	Ectopic pregnanc Other (specify)	ey .		23d. Date of de Month	elivery Day Year
rds, P	quires that n signed t uld be det	by	Part II. Other significant conditions of	ontributing to death bu	it not resulting in the u	nderlying cause gr	ven in Part I.			to the cause of death?
Il Record	The law requires that the cate has been signed by the page 2 should be detache	Completed						24a. Was ar autops perform 1 Yes 2	prior to death?	sutopsy findings available completion of cause of
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		04		th (Check only one	9)	
of	Physi this c	2	1 Yes 25 No	1 🗀 Inpatier		I 3LI DOA	The state of the s		nce 6 Other (Spe	ecify)
	ing F	lon	27. Manner of Death 1 Salatural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	Wo	rk?	28d. Describe ho	w injury occurred	
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Certification:	Accident investigation 3 □ Suicide 6 □ Could not be 4 □ Homicide determined		ry - At home, farm, str . (Specify)]Yes 2□No	28f. Location (Str. City or Town	eet and Number or R , State)	lural Route Number,
,	e Hospital 24 hours e Funeral letely filled	edical Co	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best o niner: On the basis of and manner stat	examination and/or in	h occurred at the ti vestigation, in my o	me, dale and place, opinion, death occur	and due to the ca red at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	Fo th within Fo th	Me	29b. Signature and title of certifier	20.0	7101	29c, Licens	se number	29	d. Date/signed (Mon	th, Day, Year)
7	/		Matter M.	Muza	al il	D	17000		1/19/	04
	6		30. Name and address of person who	completed cause of de	ath (Item 23a) (Type	Print)	2037	/	11/	7
	9		Walter Welzant M.		ler Drive	·	17 Torzana	Moser 1 1	21201	
	Sta	te	31. Date filed (Month, Day, Year)	22. Registra			u Lowson,	maryland	41204	-
- 50	Registr		JAN Z U ZUU	go in in	No figure	150				

	•	1 = For State Registrar	State of Maryla		artment of He rtificate of D			ene 20 (0099
Physicia		1. Decedent's Name (First, Middle, Last Russell Wade Bro					2. Date of Death Month 01	Day Ye.	A.A
/Medic Examin	er	4a. Facility Name (If not institution, give Stella Maris Hos 5. Social Security Number 6. Se	street and number)	rs. last birthday)	4b. City, Town, or L Towson If Under 1 Year	ocation of Death	8. Date of Birth	4c. County of D Baltim	eath
Funeral Director		161–18–7905 Usual Residence of Decedent	^{2M 2□ F} 81	Yrs.	Months Days	Hours Min.	(Month, Day, 03/02/1		ennsylvania
8s-f ahow	ctor	MD Baltim		City, Town or Lo Kingsvi	lle		1/	og. Citizen of What	10d. Inside City Limits 1 ☐ Yes 2√ No
if Health and Mental Hygiene. Itam 27 is marked other than "natural", or items 23s or 28s-f show other traumatic avent, the Medical Exercities itsust Le notified at	by Funeral Director	10e. Street and Number 12431 Hennessy I 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 XYes 2 □ No If Yes, Give		10f. Zip Code 21087 Was Decedent of His If Yes, specify Cuban 1 Yes 2 XNo	panic Origin? (Spe Mexican, Puerto Specify:		U.S.A. 14. Race - A Black, V	umerican Indian, /hite, etc. White
e. an "natural Medical Ex	Completed b	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation	16a. Dece (Give life.	dent's Usual Occupat kind of work done du DO NOT use retired)	ring most of worki	ng	16b. Kind of Busine	ess/Industry
ntal Hygien ed other th event, the	Be	12 17. Father's Name (First, Middle, Last)	l.a	Car	penter/Far	8. Mother's Name		Local Maiden Sumame)	101
th and Mer 17 is mark traumatic	은	Byron Henry Broom 19a. Informant's Name/Relationship (To Lena B. Brooks	ype, Print)		ng Address (Street ar		al Route Number,		e, <i>Zip Cod</i> e) 21087
nent of Heal int: If item 2 iry or other		20a. Method of Disposition 1 ↑ Burial 2 □ Cremation 3 □ ↑ 4 □ Donation 5 □ Other (Specify,	20t Removal from State	. Place of Dispo cemetery, cre	osition (Name of matory or other place) Stian Cem	, .		20c. Location - City	
Department of H Important: If its any injury or of once.		21. Signature of Funeral Service Licen-	rasakn	1	1750 Belai	r Road -	Kingsvi	lle, MD	al Home, P.A 21087
otysician and Medical xaminer transit the prival-transit	dical Examiner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	a. END STAGE Due to (or as a const.) Due to (or as a const.) Due to (or as a const.)	sequence of):	SON'S DISE	ASE			Interval Between Onset and Death
y the attending phys ached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3[□Ectopic pregnancy □ Other (specify)			23d. Date of Month	delivery Day Year
gned b	þ	Part II. Other significant conditions of	ontributing to death but not	resulting in the u	underlying cause giver	n in Part I.			e to the cause of death? Probably 4X Unknown
certificate has been sirrector, page 2 should t	Completed				<u>-</u>		24a. Was an autops perform	y prior ned? deat	autopsy findings available to completion of cause of h? Yes 2 \(\sumbolear\) No
artifica ctor.	Be	25. Was case referred to medical examiner?				26. Place of Deatl			-
h. After this funeral d	၉	1 Yes 2 X No 27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year	28b. Time o	of 28c. Injury Work	at		nce 6 NOther (Specify) HOSPICE
	Certification:	3 Suicide 6 Could not be determined		t home, farm, st	reet, factory, office		28f. Location (St City or Town	reet and Number o , State)	r Rural Route Number,
within 24 hours after	Medical	(Check only 2 Medical Examone)	ysician: To the best of my niner: On the basis of exam and manner stated.	knowledge, dea unation and/or in	nvestigation, in my opi	nion, death occur	red at the time, da	ate and place, and	due to the cause(s)
To Some	Σ	29b. Signature and title of certifier	200		29c. License	3725	29	ed. Date signed (M	SIOY
1	ate	30. Name and address of person who of the second se	OOD 2300 DUI	ANEY VA	ALLEY RD.	TIMONIUM	1, MD 21	093	

3:30 a.m.

JANUARY 13, 2004

RUSSELL BROOKS

Charles D. Berry 04-0349 **AKG**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

7.	
State of Maryland / Department of Health and M	lental Hygiene
Certificate of Death	Reg. No.

3	-		1 - State Registrar		ътате от м	aryland	-	rtificate				Reg. N	2004		199:
	Dhysioi	20	Decedent's Name (First, Middle, Last)					2. Date of De. Month			eath Da	ay Yea		ne of Death	
	Physici /Medi	cal	Charles David Berry 4a. Fecility Name (If not institution, give street and number)					4b. City, Town, or Location of Death					.3, 2004 c. County of De		15 P ^M
4	Examir	ıer	9400 Livingston												
-			5. Social Security Number	6. Sex		ge (In yrs. la	st birthday)	If Under 1	Year	ishingto	8. Date of B	irth	Prince	Georg	tate or Foreig
	Funeral Director		577-68-8218		¹ ² □ F 53		Yrs.	Months	Days	Hours Min	8. Date of B (Month, D 10/30)	1950 1950) Wa	Journey)	on,DC
	P _	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location									10d Inci	de City Limits		
	Marylar f show		M 1 1D C . I E . II I .									Yes 2∭ No			
	28a-	ect	10e. Street and Number			1		10f. Zip Code 10g. Citizen of What						Country?	
	h with 23e or	Funeral Director	10814 Hill Top Drive					20744					USA		
	deat	ner	11. Marital Status	12	. Was Decedent Armed Forces?	Ever in U.S	. 13.	Was Decede	nt of His	spanic Origin? (S	Specify Yes or N to Rican, etc.)	lo-	14. Race - Ar Black, W		an,
980	72 hours after death with the Maryland "natural", or Itams 23a or 28a-f show dical Examiner must be notified at	by Fu	1 Never Married 2 Marri 3 Widowed 4XXDivorced		1 ☐ Yes 2 Ĭ ☐ No			1 Yes 2 No Specify:				Specify: White			
Ò	2 ho	ted	15. Deceden	t's Educat	tion		16a. Dece	dent's Usual	Occupat	tion	ndkina	18b. I	Kind of Busines	s/Industry	
Baltimore, Maryland 21215-0036	C 2	To Be Completed by	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)			5+)	(Give kind of work done during most of worki life. DO NOT use retired)				g		Commission		
	filed within Hygiene. other than		12th Clerk					k					Securities Exchange		
			17. Father's Name (First, Middle,								me (First, Middi				
			Carroll Eugene Berry Pearl Geneva Walto												
	12 sh h and 7 is m troum		19a. Informant's Name/Relationship (Type, Print) Carroll E. Berry/Father 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10814 Hill Top Drive Fort Washington, MD. 20744												
	permit. Peges 1 and 3 Department of Heelth Important: If item 27 any injury or other tri <u>once</u> .		20a. Method of Disposition 1 ABurial 2 Cremation 3 Removal from State 1 Donatiop 5 Other (Specify) 20b. Place of Disposition (Name of commetery, crematory or other place) Cedar Hill Cemetery 1/17/2004 Suitland, Md.												
			21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Geo. Kalas Funeral Ho												
Ba	permit. Departr Importa eny inje		Mar P.4	de	46.						Oxon F				
	Physician	Examiner	23a. Part1. Enter the disease, or	complica	tion that cause	d the death.	Do not ent	er the mode	of dying	, such as cardia	c or respiratory	arrest,		Approx	ximate al Between
			shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. Ahorosclerotic Cardiovascular disease.									and Death			
	/Medical		disease or condition resulting in death) a. One to (or as a consequence of):						Courryweller acrose					-	
	Examiner														
	ufficate be executed g physician and as the burial-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) •	Due to (or as a consequence of):										
/			cause, Enter Underlying Cause (Disease or injury that initiated events c.												
6															
68760,	te be ysicia ne bu	edical	d												
	ntifica ng ph as th		IE EEMALE:												
Vital Records, P.O. Box	law requires that the death cert as been signed by the attending 2 should be detached for use a	ed by Physician/M	IF FEMALE: 23c. If yes, outcome of pregnancy 1							23d. Date of delivery Month Day Year					
			in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknown							,					
			9 Unknown Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?												
			Partin, Other significant conditions continuous to treat out not resulting in the underlying cause gives in react.								2 No 3 Probably 4 Unknown				
CO	law requir as been si 2 should	plete									24a. Wa		24b. Were	autopsy find	lings available of cause of
Re	he h	Completed										opsy formed? 2 \Baselin No.	death	7	
ital	ician: T certificat ector, p	ertification: To Be C	25. Was case referred to medical 26. Place of Death (Check only one)												
	di is		D XXYes 2 No Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 12 her (5							6 her (Sp	ecify) At	scene			
	ing After une		27. Manner of Death 1 ☑Natural 5 ☐ Pendir 2 ☐ Accident investi		28a. Date of Inju (Month, Da	28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No			28d. Describe how injury occurred					
Division	l or Attend after death Director: /		3 Suicide 6 Could determ	jury - At hon tc. (Specify)	- At home, farm, street, factory, office				28f. Location (Street and Number or Rural Route Number, City or Town, State)						

Medical Certification: To Be

To the Hospitel or Attending Physicier within 24 hours after death.

To the Funerel Director: After this certif completely filled in by the funeral directo

29b. Signature and title of certifier

4 - Homicide 29a. Certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 **Typedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

O.C.M.E. (Item 23a) (Type, Print)

January 14, 2004

State Registrar

111 Penn Street, Baltimore, Maryland 21201 200432. Registrar's Signature 31. Date filed (Month, Days Ve

		•	For Stete Registrar	State of Maryland		rtment of H		Mental Hygier	- 71111	4 01000		
J.	Physicia /Medic		1. Decedent's Name (First, Middle, Lass Sun Hee	Cho				2. Date of Death Month January	16, Z00	3. Time of Death 4 11, 55 Pm		
	Examir		4a. Facility Name (If not institution, give S. Social Security Number 6. Se	Nursing Cen	Her	4b. City, Town, or When	A TOM If Under 24 Hrs	8 Date of Birth	4c. County of Dea	nth gomery Co. thplace (State or Foreign		
	Funeral Director			M 2/20 F 93	Yrs.	Months Days	Hours Min	. (Month, Day, Yea	910 Se	ountry Korea		
	within 72 hours after death with the Maryland ane. then "natural", or Itams 23e or 28e-f ehow he Medical Examiner man De notified at	tor	Maryand Monta		Ver.	spring				10d. Inside City Limits 1 ☐ Yes 2月1No		
		Funeral Director	10e. Street and Number 14000 New Ham	pshire Ave.		10f. Zip Code	104-62	_	Citizen of What C	A		
5-0036	urs after deat al', or Itams 2 Examiner un	Ď	11. Marital Status 1 Never Mamed 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 No II Yes, Give Year or Dates:	į –	/as Decedent of Hi Yes, specify Cuba □ Yes 22 No	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi			
21215-0	permit. Peges 1 and 2 should be filed within 72 hours'after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-f ehow emportant: If Item 27 is marked other then "natural", or Items 20 or 28a-f ehow empty injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)	(Give I	ent's Usual Occupa ind of work done of ONOT use retired TOME	ation during most of wo Make (orking 16b.	Kind of Business	Andustry Home		
T		To Be C	17. Father's Name (First, Middle, Last) Unk	Le.	e		18. Mother's Na	me (First, Middle, Maid	en Sumame)	Lee		
Marylan			19a. Informant's Name/Relationship (7)	ype, Print) (Son)	- 5	Address (Street a		ural Route Number, City SVIIIe, M.	yor Town, State,	Zip Code)		
Baltimore,			20a. Method of Disposition 1. Solution 2 □ Cremation 3 □ 1. Other (Specify)	Removal from State	ace of Dispos metery, crem Ney Va	ition (Name of atory or other place)	on id. 1-	1	Location - City of	1. 1		
Balt			21. Signature & Funeral Service Licens	Jan, Dr.	Pe.	Name and Address aceful 2325	Alterna OCK Rd	. Timoni	eral+Crei	ngtion Center 2.21093		
	ding Physician: The law requires that the death cartificate be executed by the attending physician and a remaind in a reconstitution of the attending physician and a remaind in a remaind		23a. Part 1. Enter the disease, or comp shock, or heart lature. List only of Immediate Cause (Final disease or condition	loations that caused the death he cause on each line. Brain St	Do not ente	the mode of dying	g, such as cardia	c or respiratory arrest,		Approximate Interval Between Onset and Death aweeks		
8			resulting in death)	Due to (or as a consequence of): Aspiration Pneumonia								
		Examiner	Sequentiarly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c. A zheim	3 years							
,092		by Physician/Medical Ex	resulting in death) Last	d. Urosepsi.	,				3 weeks			
O. Box 68			IF FEMALE: 23b. Was decedent pregnant in the past 12, months? 1 ☐ Yes 2 Ø No 9 ☐ Unknown	23c. If yes, outcome of pregnar 1□Live birth 2□Felal 4□Pregnant at time of de 9□Unknown	death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of de Month	nlivery Day Year		
<u>α</u>												
I Records,		Completed						autopsy prior to completion of cause performed?				
Vital		Be	25. Was case referred to medical axaminer?									
o	Physic r this cral dir	To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatient 28b. Time of	3 DOA	A Nursing Home 5 Hesidence 6 Other (Specify)					
ion	Attending r death. ector: After by the fune	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury Work?								
Division	To the Hospitel or Attendit within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	et, factory, office		281. Location (<i>Street and Number or Rural Route Number,</i> City or Town, State)					
*		29a. Certifier (Check only one) 29a. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as (Check only one) 29a. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as death occurred at the time, date and place, and due and manner stated.								s stated. e to the cause(s)		
7	To th withir To th comp	Me	29b. Signature and title of certifler	e Cres	1	29c. License	1033		Date signed (Mon	in, Day, Year) 17, 2004		
	.7		Byoung K. Lee, M.D. 13000 Georgia Ave. Silver Spring, MD. 20906									
	Sta Regist		31. Date filed (Morth, Day, Year)	32. Regietrar's Signat	ure	Soules						